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Sequence Number: 08-19-20
Notice ID(s): 3147
File Date: 8/14/2020

Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 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:	Division of TennCare
Contact Person:	George Woods
Address:	Division of TennCare 310 Great Circle Road Nashville, TN 37243
Phone:	(615) 507-6446
Email:	george.woods@tn.gov

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:	Talley A. Olson, Director TennCare, Office of Civil Rights Compliance
Address:	Division of TennCare 310 Great Circle Road Nashville, TN 37243
Phone:	(855) 857-1673 TTY dial 711 and ask for 855-857-1673
Email:	hcfa.fairtreatment@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Division of TennCare 310 Great Circle Road, Conference Room 1 East A		
City:	Nashville, TN		
Zip:	37243		
Hearing Date:	October 6, 2020		
Hearing Time:	5:00 p.m.	<input checked="" type="checkbox"/> CST/CDT	<input type="checkbox"/> EST/EDT

Additional Hearing Information:

Members of the public may submit written comments for consideration at the hearing until 5:00 p.m. Central Time on October 6, 2020. Written comments should be sent via email to george.woods@tn.gov.

If attending in-person, please bring identification so that you may be checked into the building.

COVID Building Entry Protocols:

As part of the Tennessee Pledge, TennCare observes and is compliant with the following building entry protocols:

- At this time, all persons working or meeting in the TennCare building are required to wear a face mask.
- We recommend meeting attendees bring their own mask, however, if an attendee does not have one, a mask will be provided to any attendee upon entry.
- Additional personal protection equipment (PPE) such as a face shield are permitted but are not a

replacement for a face mask.

- Upon entry, persons are required to complete a health screening by answering the following questions:
 1. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days? (Note: This does not apply to medical personnel, first responders, or other individuals who encounter COVID-19 as part of their professional or caregiving duties while wearing appropriate PPE.)
 2. Are you experiencing a cough, shortness of breath or sore throat?
 3. Have you had a fever in the last 48 hours?
 4. Have you had new loss of taste or smell?
 5. Have you had vomiting or diarrhea in the last 24 hours?
- Persons working or meeting in the TennCare building are also required to submit to a temperature screening; persons with temperatures 100.4 degrees or higher will not be permitted to enter the building. However, an opportunity will be provided to submit comments in writing instead of in-person.

*****NOTICE*****

Currently, Governor Lee's Emergency Order pertaining to COVID-19 that allows State Boards to hold their meetings electronically is set to expire August 29, 2020. If it does expire on that date, then this hearing will be an in-person hearing at the location and time denoted just above. If the Emergency Order is extended beyond the scheduled date of this hearing, then this hearing will be held electronically via WebEx.

In the event of an electronic hearing, members of the public may join the WebEx at the following link:

<https://tngov.webex.com/tngov/j.php?MTID=me6f71e945ea232283b746a222dc2ad51>

The link above should take users directly to the rulemaking hearing. If prompted for a meeting number or password, use:

Meeting number (access code): 171 972 5245

Meeting password: tenncare

It is recommended that interested persons join the WebEx several minutes early to ensure adequate time to install any mandatory plugins in order to attend the electronic rulemaking hearing.

Revision Type (check all that apply):

Amendments

New

Repeal

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

Chapter Number	Chapter Title
1200-13-21	CoverKids
Rule Number	Rule Title
1200-13-21-.02	Definitions
1200-13-21-.04	Enrollment and Reassignment
1200-13-21-.05	Benefits
1200-13-21-.06	Exclusions
1200-13-21-.07	Cost Sharing
1200-13-21-.08	Disenrollment
1200-13-21-.09	Review of CoverKids Decisions
1200-13-21-.10	Providers

Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to

<https://sos.tn.gov/products/division-publications/rulemaking-guidelines>.

Chapter 1200-13-21 CoverKids Table of Contents is amended by inserting new rule number and title "1200-13-21-

.04 Enrollment and Reassignment” following rule number “1200-13-21-.03 Eligibility” and renumbering existing rule “1200-13-21-.04 Benefits” as rule “1200-13-21-.05 Benefits”, and is further amended by inserting new rule number and title “1200-13-21-.06 Exclusions” following renumbered rule “1200-13-21-.05 Benefits” and renumbering subsequent rules appropriately so that, as amended, the Table of Contents shall read as follows:

1200-13-21-.01	Scope and Authority
1200-13-21-.02	Definitions
1200-13-21-.03	Eligibility
1200-13-21-.04	Enrollment and Reassignment
1200-13-21-.05	Benefits
1200-13-21-.06	Exclusions
1200-13-21-.07	Cost Sharing
1200-13-21-.08	Disenrollment
1200-13-21-.09	Review of CoverKids Decisions
1200-13-21-.10	Providers

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 4-5-204, 71-5-105, 71-5-109 and 42 C.F.R. Part 455 Subpart E.

Rule 1200-13-21-.02 Definitions Paragraph (1) Covered services is amended by deleting the definition and replacing it with a new definition so as amended Paragraph (1) shall read as follows:

- (1) Covered services. Benefits and services listed in this Chapter and provided for enrollees in the CoverKids program by an MCO, DBM, PPA or other entity under contract with the Division of TennCare.

Rule 1200-13-21-.02 Definitions Paragraph (2) CoverKids is amended by deleting the period at the end of the definition and inserting the punctuation and language “, administered through the Division of TennCare, which provides health coverage for children under nineteen (19) years of age and pregnant women, who do not have health insurance and do not qualify for TennCare.” so as amended Paragraph (2) shall read as follows:

- (2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires, administered through the Division of TennCare, which provides health coverage for children under nineteen (19) years of age and pregnant women, who do not have health insurance and do not qualify for TennCare.

Rule 1200-13-21-.02 Definitions Paragraph (3) CoverKids network is amended by deleting the language “the Plan Administrator or Dental Benefits Manager” and replacing it with the language “an MCO, DBM, PPA or other entity under contract with the Division of TennCare” and is further amended by deleting the last sentence so as amended Paragraph (3) shall read as follows:

- (3) CoverKids network. A group of health care providers that have entered into contracts with an MCO, DBM, PPA or other entity under contract with the Division of TennCare to furnish covered services to CoverKids enrollees.

Rule 1200-13-21-.02 Definitions is amended by inserting a new Paragraph (4) CoverKids Pregnant Women and by renumbering existing Paragraph (4) and subsequent paragraphs appropriately so as amended Paragraph (4) shall read as follows:

- (4) CoverKids Pregnant Women. The part of the CoverKids program that provides coverage for the unborn children of pregnant women with no source of health coverage who meet the CoverKids eligibility requirements.

Rule 1200-13-21-.02 Definitions Paragraph (4) renumbered as (5) CoverKids provider is amended by deleting the definition and replacing it with a new definition so as amended Paragraph (5) shall read as follows:

- (5) CoverKids provider. A provider who accepts as payment in full for furnishing benefits to a CoverKids enrollee, the amounts paid pursuant to an approved agreement with a TennCare contractor. Such payment may include copayments from the enrollee or the enrollee’s responsible party. A CoverKids provider, including an Out-of-State Emergency Provider as defined in Rule 1200-13-13-.01, must be enrolled with TennCare and must abide by all CoverKids rules and regulations, including requirements regarding provider billing of patients as

found in Rule .10. CoverKids Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in the federal Medicare, Medicaid or CHIP programs.

Rule 1200-13-21-.02 Definitions is amended by inserting a new Paragraph (9) Managed Care Organization (MCO) and by renumbering existing Paragraph (9) and subsequent paragraphs appropriately so as amended Paragraph (9) shall read as follows:

- (9) Managed Care Organization (MCO). An appropriately licensed Health Maintenance Organization (HMO) approved by the Division of TennCare as capable of providing medical, behavioral, and long-term care services which has signed a Contractor Risk Agreement with the Division of TennCare and operates a provider network to provide covered services to CoverKids enrollees.

Rule 1200-13-21-.02 Definitions Paragraph (9) renumbered as (11) Non-CoverKids provider is amended by deleting the language and punctuation "Plan Administrator's or Dental Benefits Manager's network." and replacing it with new language and punctuation "network of a TennCare-contracted MCO or other entity contracted to administer CoverKids benefits." so as amended Paragraph (11) shall read as follows:

- (11) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the network of a TennCare-contracted MCO or other entity contracted to administer CoverKids benefits.

Rule 1200-13-21-.02 Definitions Paragraph (11) renumbered as (13) Plan Administrator or PA is amended by deleting the paragraph and replacing it with a new paragraph so as amended Paragraph (13) shall read as follows:

- (13) Pharmacy Plan Administrator (PPA). The entity responsible for the administrative services associated with providing pharmaceutical related covered services to CoverKids enrollees.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Chapter 1200-13-21 is amended by inserting a new Rule 1200-13-21-.04 Enrollment and Reassignment and renumbering existing Rule .04 and all subsequent rules appropriately so as amended the new Rule .04 shall read as follows:

1200-13-21-.04 ENROLLMENT AND REASSIGNMENT.

- (1) Enrollment. CoverKids enrollees are enrolled into Managed Care Organizations for the provision of covered medical and behavioral health services, a Dental Benefits Manager for provision of covered dental services, and a Pharmacy Plan Administrator for administration of covered pharmacy services. 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) Managed Care Organizations (MCOs).

- 1. Individuals or families determined eligible for CoverKids shall select an MCO at the time of application. The MCO must be available in the Grand Division of the State in which the enrollee lives. All family members living in the same household and enrolled in CoverKids must be assigned to the same MCO. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Division of TennCare will assign each enrollee to an MCO that is accepting new enrollees.
- 2. A CoverKids enrollee may change MCOs one (1) time within the initial ninety (90) 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 accepting new enrollees. No additional changes will be allowed except as otherwise specified in this rule. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Division of TennCare 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:
 - (i) 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.
 - (ii) 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 .10.
- (b) Dental Benefits Manager (DBM). CoverKids children shall be assigned to the DBM under contract with the Division of TennCare to provide dental benefits through the CoverKids Program.
- (c) Pharmacy Plan Administrator (PPA). CoverKids enrollees shall be assigned to the PPA under contract with the Division of TennCare to provide pharmacy benefits for both medical and behavioral health services through the CoverKids Program.
- (2) Reassignment.
- (a) Reassignment to an MCO other than the current MCO in which the CoverKids enrollee is enrolled is subject to another MCO’s capacity to accept new enrollees and must be approved by the Division of TennCare in accordance with one of the following:
1. During the initial ninety (90) day period following notification of MCO assignment as described at paragraph (1), a CoverKids enrollee may request a change of MCOs.
 2. A CoverKids enrollee must change MCOs if he moves outside the MCO’s Grand Division, and that MCO is not authorized to operate in the enrollee’s new place of residence. Until the CoverKids enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.
 3. If an enrollee’s MCO withdraws from participation in the CoverKids Program, TennCare will assign him to an MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have ninety (90) days to select another MCO in his Grand Division.
 4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Division of TennCare authorizes a change as the result of the resolution of an appeal requesting a “hardship” reassignment. When an enrollee changes MCOs, the enrollee’s medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in CoverKids shall also be changed.
- (b) A CoverKids enrollee may change MCOs if the Division of TennCare has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.

1. The following situations will not be determined to be “hardships”:
- (i) The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as stated in Part 2 below);
 - (ii) The enrollee claims lack of access to services but the plan meets the state’s access standard;
 - (iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
 - (iv) The enrollee is concerned that a current provider might drop out of the plan in the future;
 - (v) The enrollee’s PCP is no longer in the MCO’s network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.
2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.
 - (i) A member has a medical condition that requires complex, extensive, and ongoing care; and
 - (ii) The member’s specialist has stopped participating in the member’s current MCO network and has refused continuation of care to the member in his current MCO assignment; and
 - (iii) The ongoing medical condition of the member is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and
 - (iv) The current MCO has been unable to negotiate continued care for this member with the current specialist; and
 - (v) The current provider of services is in the network of one or more alternative MCOs; and
 - (vi) An alternative MCO is available to enrolled members (i.e., has not given notice of withdrawal from the CoverKids Program, is not in receivership, and is not at member capacity for the member’s region).
- (c) Requests to change MCOs submitted by CoverKids enrollees shall be evaluated in accordance with the hardship criteria referenced in Subparagraph (b) above. If an enrollee’s request to change MCOs is granted due to hardship, all family members living in the same household and enrolled in CoverKids will be assigned to the new MCO. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of Rule .09.
 - (d) The Division of TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, or spouse.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children’s Health Insurance Program State Plan.

Rule 1200-13-21-.04 renumbered as 1200-13-21-.05 Benefits Paragraph (2) is amended by deleting the word “and” preceding the word “vision” and inserting the punctuation and language “, and hearing aids and cochlear implants” following the words “vision services” so as amended Paragraph (2) shall read as follows:

- (2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, vision services, and hearing aids and cochlear implants are not covered for these enrollees.

Rule 1200-13-21-.04 renumbered as 1200-13-21-.05 Benefits is amended by deleting current Paragraph (4) and inserting a new Paragraph (4) so as amended Paragraph (4) shall read as follows:

- (4) An MCO or DBM may provide non-covered items or services as cost effective alternatives to covered items or services. Such cost effective alternative services may be provided because they are either (1) alternatives to covered CoverKids services that, in the judgment of the MCO or DBM, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the judgment of the MCO or DBM, would require more costly treatment in the future. Cost effective alternative services are not covered services and are provided only at the discretion of the MCO or DBM, subject to approval by TennCare.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Chapter 1200-13-21 is amended by inserting a new Rule 1200-13-21-.06 Exclusions and renumbering existing Rule .06 and all subsequent rules appropriately so as amended the new Rule .06 shall read as follows:

1200-13-21-.06 EXCLUSIONS.

- (1) The services and items set out in the TennCare Medicaid Exclusions Rule 1200-13-13-.10(1) and (3)(b) are excluded from coverage by the CoverKids program.
- (2) In addition to the services and items excluded by paragraph (1), the following services, products and supplies are also excluded from coverage by the CoverKids program:
 - (a) Audiological therapy or training
 - (b) Beds and bedding equipment as follows:
 1. Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress
 2. Bead beds, or similar devices
 3. Bed boards
 4. Bedding and bed casings
 5. Ortho-prone beds
 6. Oscillating beds
 7. Springbase beds
 8. Vail beds, or similar bed
 - (c) Biofeedback
 - (d) Cushions, pads, and mattresses as follows:
 1. Aquamatic K Pads
 2. Elbow protectors
 3. Heat and massage foam cushion pads
 4. Heating pads
 5. Heel protectors

- 6. Lamb's wool pads
- 7. Steam packs
- (e) Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules
- (f) Ear plugs
- (g) Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an Enrollee who uses a wheelchair and who has limited or no ability to stand on his own
- (h) Food supplements and substitutes including formulas
- (i) Humidifiers (central or room) and dehumidifiers
- (j) Medical supplies, over-the-counter, as follows:
 - 1. Alcohol, rubbing
 - 2. Band-aids
 - 3. Cotton balls
 - 4. Eyewash
 - 5. Peroxide
 - 6. Q-tips or cotton swabs
- (k) Nutritional supplements and vitamins
- (l) Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
- (m) Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
 - 1. Explanation of continuing medical necessity for the item, and
 - 2. Explanation that the item was stolen or destroyed, and
 - 3. Copy of police, fire department, or insurance report if applicable
- (n) Radial keratotomy
- (o) Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed
- (p) Repair of DME items not covered by CoverKids
- (q) Repair of DME items covered under the provider's or manufacturer's warranty
- (r) Repair of a rented DME item
- (s) Standing tables

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.05 renumbered as 1200-13-21-.07 Cost Sharing Paragraph (2) Subparagraph (a) is amended by deleting existing Part 4. and renumbering existing Part 5. as Part 4. and is further amended by adding the parenthetical phrase "(well-child visits)" following the word "assessments" so as amended Part 4. shall read as follows:

4. Routine health assessments (well-child visits) and immunizations given under American Academy of Pediatrics guidelines.

Rule 1200-13-21-.05 renumbered as 1200-13-21-.07 Cost Sharing Paragraph (3) is amended by deleting the language "5 percent" and replacing it with the language "five percent (5%)" so as amended Paragraph (3) shall read as follows:

- (3) An enrollee's annual cost sharing obligations shall not exceed five percent (5%) of his household's annual income.

Rule 1200-13-21-.05 renumbered as 1200-13-21-.07 Cost Sharing is amended by adding new Paragraphs (5) and (6) so as amended Paragraphs (5) and (6) shall read as follows:

- (5) Children receiving hospice services are exempt from all copay requirements.
- (6) Pregnant enrollees are exempt from all copay requirements.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (2) is amended by deleting the words "Health Services" in the first sentence and replacing them with the words "Adverse Medical and Dental Benefit Determination" and is amended by deleting the word "health" wherever it appears in the second sentence and replacing it with the words "medical and dental" and is further amended by deleting the language "the following provisions:" and replacing it with the language "Rule 1200-13-13-.11, except that enrollees shall not be entitled to continuation of benefits pursuant to 42 CFR § 457.1260." so as amended Paragraph (2) shall read as follows:

- (2) Adverse Medical and Dental Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate medical and dental services, or a failure to approve, furnish, or provide payment for medical and dental services in a timely manner, according to Rule 1200-13-13-.11, except that enrollees shall not be entitled to continuation of benefits pursuant to 42 CFR § 457.1260.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (2) is amended by inserting a new Paragraph (3) immediately preceding Subparagraphs (a) through (e) and by renumbering subsequent paragraphs appropriately so as amended Paragraph (3) shall read as follows:

- (3) Adverse Pharmacy Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate pharmacy services, or a failure to approve, furnish, or provide payment for pharmacy services in a timely manner, according to the following provisions:

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (a) is amended by deleting the word "health" wherever it appears and replacing it with the word "pharmacy" so as amended Subparagraph (a) shall read as follows:

- (a) Notice. Any decision denying or delaying a requested pharmacy service, reducing, suspending or terminating an existing pharmacy service, or failure to approve, furnish or provide payment for pharmacy services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing pharmacy services may continue pending review unless there is question that the existing pharmacy services are harmful.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (b) is amended by inserting the word "Pharmacy" before the words "Plan Administrator" and by deleting the language "(PA) or Dental Benefits Manager (DBM)" and replacing it with the parenthetical "(PPA)" and is further amended by deleting the language "PA or DBM" wherever it appears and replacing it with the acronym "PPA" so as amended Subparagraph (b) shall read as follows:

- (b) Pharmacy Plan Administrator (PPA) Review. A parent or authorized representative may commence the review process by submitting a written request to the PPA within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action, not to exceed six (6) months from when the action occurred. The PPA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (c) is amended by deleting the language "PA's or DBM's" wherever it appears and replacing it with the acronym "PPA's" so as amended Subparagraph (c) shall read as follows:

- (c) State Informal Review. After the PPA's internal review is completed, the parent or authorized representative of an enrollee who disagrees with the decision may request further review by telephone or by submitting a letter or form to the Division of TennCare, CoverKids Appeals, which must be received within 8 days of the PPA's decision. The Appeals Coordinator will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator will request review by the state's independent medical consultant and a written decision will be issued within 20 days of receipt of the request for further review.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (e) is amended by deleting the words "health or dental" and replacing them with the word "pharmacy" and further is amended by deleting the language "PA or DBM" wherever it appears and replacing it with the acronym "PPA" so as amended Subparagraph (e) shall read as follows:

- (e) Time for Reviews. Review of all non-expedited pharmacy services appeals will be completed within 90 days of receipt of the initial request for review by the PPA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each of the PPA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (1) is amended in Subparagraph (a) by deleting the word "rule" and replacing it with the word "Chapter" and Paragraph (1) is further amended by deleting the language "PA or DBM" wherever it appears in Subparagraphs (a) through (c) and replacing it with the language "MCO, DBM, or PPA" so as amended Paragraph (1) Subparagraphs (a) through (c) shall read as follows:

- (a) All CoverKids providers, as defined in this Chapter, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the MCO, DBM, or PPA, plus any copayment required by the CoverKids program to be paid by the individual.
- (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the MCO, DBM, or PPA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the MCO, DBM, or PPA plus any copayment required by the CoverKids program to be paid by the individual.
- (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless

these services are authorized by the MCO, DBM, or PPA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the MCO, DBM, or PPA does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (2) Subparagraph (a) is amended by deleting the language "PA or DBM" wherever it appears and replacing it with the language "MCO, DBM, or PPA" so as amended Subparagraph (a) shall read as follows:

- (a) When the MCO, DBM, or PPA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the MCO, DBM, or PPA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers is amended by inserting new Paragraphs (3) and (4) and renumbering existing Paragraph (3) as Paragraph (5) and all subsequent Paragraphs appropriately so as amended new Paragraphs (3) and (4) shall read as follows:

- (3) Participation in the CoverKids program will be limited to providers who:
 - (a) Accept, as payment in full, the amounts paid by the MCO, DBM, or PPA, including copays from the enrollee, or the amounts paid in lieu of the MCO, DBM, or PPA by a third party (Medicare, insurance, etc.);
 - (b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Substance Abuse Services, if appropriate;
 - (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);
 - (d) Agree to maintain and provide access to the Division of TennCare and/or its agent all CoverKids enrollee medical records for ten (10) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;
 - (e) Provide medical assistance at or above recognized standards of practice; and
 - (f) Comply with all contractual terms between the provider and the MCO, DBM, or PPA (as appropriate) and CoverKids policies as outlined in federal and state rules and regulations and CoverKids provider manuals and bulletins.
 - (g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:
 1. The provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.
 2. The Division of TennCare may withhold or recover payments to an MCO, DBM, or PPA in cases of provider fraud, willful misrepresentation, or flagrant noncompliance with contractual requirements and/or CoverKids policies.
 3. The Division of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.
 4. The Division of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person

who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the US Title XX Services Program since the inception of these programs.

5. The Division of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.
6. The Division of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare, Medicaid, or CHIP for federal financial participation.
7. The Division of TennCare may recover from an MCO, DBM, or PPA any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Division of TennCare may terminate the provider's participation in CoverKids.

(4) Solicitations and Referrals

- (a) MCOs, DBMs, PPAs, and providers shall not solicit CoverKids enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with CoverKids-covered services that are not medically necessary and/or that overutilize the CoverKids program.
- (b) An MCO, DBM, or PPA may request a waiver from this restriction in writing to the Division of TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The MCO, DBM, or PPA may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.
- (c) CoverKids payments for services related to a non-waivered solicitation enticement shall be considered by the Division of TennCare as a non-covered service and recouped. Neither the managed care contractor nor the provider may bill the enrollee for non-covered services recouped under this authority.
- (d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (3) renumbered as Paragraph (5) Subparagraph (b) Part 1. Subpart (iii) and Part 2. are amended by deleting the language "PA or DBM" wherever it appears and replacing it with the language "MCO, DBM, or PPA" so as amended Paragraph (5) Subparagraph (b) Part 1. Subpart (iii) and Part 2. shall read as follows:

- (iii) The enrollee's MCO, DBM, or PPA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.
2. The provider submits a claim for service to the MCO, DBM, or PPA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated MCO, DBM, or PPA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (4) renumbered as Paragraph (6) Subparagraphs (b) and (e) are amended by deleting the language "PA or DBM" wherever it appears and

replacing it with the language “MCO, DBM, or PPA” so as amended Paragraph (6) Subparagraphs (b) and (e) shall read as follows:

- (b) The claim submitted to the MCO, DBM, or PPA for payment was denied due to provider billing error or a CoverKids claim processing error.
- (e) The provider failed to submit or resubmit claims for payment within the time periods required by the MCO, DBM, PPA, or CoverKids.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers is amended by inserting new Paragraphs (7) through (9) following existing Paragraph (4) renumbered as Paragraph (6) and renumbering subsequent Paragraphs appropriately so as amended new Paragraphs (7) through (9) shall read as follows:

- (7) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided if the provider informs the person that CoverKids assignment will not be accepted whether or not eligibility is established retroactively.
- (8) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided. Providers may bill such persons at the provider’s usual and customary rate for the services rendered. However, all monies collected for CoverKids-covered services rendered during a period of CoverKids eligibility must be refunded when a claim is submitted to CoverKids if the provider agreed to accept CoverKids assignment once retroactive CoverKids eligibility was established.
- (9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII Medicare in order to be certified as providers under the CoverKids program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by the Division of TennCare as an acute care hospital as of the date of enrollment in CoverKids. Children’s hospitals and State mental hospitals may participate in CoverKids without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers is amended by inserting new Paragraph (11) following existing Paragraph (5) renumbered as Paragraph (10) so as amended new Paragraph (11) shall read as follows:

- (11) All claims must be filed with an MCO, DBM, or PPA must be submitted in accordance with the requirements and timeframes set forth in the MCO, DBM, or PPA’s contract.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children’s Health Insurance Program State Plan.

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: August 14, 2020

Signature: 

Name of Officer: Stephen Smith

Director, Division of TennCare

Title of Officer: Tennessee Department of Finance and Administration

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Tre Hargett
Secretary of State

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