Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-13
TennCare Medicaid

Statement of Necessity Requiring Public Necessity Rules

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain eligibility amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This amendment enables the State to disenroll non-pregnant adult Medically Needy individuals upon the expiration of their current eligibility periods.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 729 Church Street, Nashville, Tennessee 37247-6501 or by telephone at (615) 741-0145.

J. D. Hickey
Deputy Commissioner
Tennessee Department of Finance
and Administration

Public Necessity Rules

of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-13
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Amendment

Rule 1200-13-13-.01 Definitions is amended by adding new paragraphs (69) and (101) and renumbering current paragraph (69) as (70) and current paragraph (101) as (102) and renumbering subsequent paragraphs accordingly so as amended new paragraphs (69) and (101) shall read as follows:

(69) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(101) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to terminate coverage for currently enrolled non-pregnant Medically Needy adults age twenty-one (21) or older at the expiration of their current eligibility periods.

Rule 1200-13-13-.02 Eligibility paragraph (4) is amended by adding subparagraph (c) which shall read as follows:

(c) The individual who is eligible as a non-pregnant Medically Needy adult in accordance with Rule 1240-2-1-.03 of the Department of Human Services is found to meet the following criteria:

1. S/he is aged twenty-one (21) or older,

2. S/he has completed his/her twelve (12) month period of eligibility for TennCare, and

3. S/he has not been determined eligible in an open Medicaid category.

Rule 1200-13-13-.02 Eligibility is amended by adding paragraph (7) which shall read as follows:

(7) Disenrollment Related to TennCare Medicaid Eligibility Reforms

Prior to the disenrollment of adult non-pregnant Medically Needy TennCare enrollees based on coverage terminations resulting from TennCare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following.

(a) Ex Parte Review

DHS will conduct an ex parte review of eligibility for open Medicaid categories for all non-pregnant adult Medically Needy enrollees in eligibility groups due to be terminated as part of the TennCare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

(b) Request for Information

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all non-pregnant adult Medically Needy enrollees in eligibility groups being terminated pursuant to the TennCare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to TDHS and to provide TDHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day timeframe for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health, mental health, or learning problem, or a disability, or limited English proficiency are unable to respond timely, as an alternative to imposing a standard with no exceptions whatsoever. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of TDHS. Only one thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by TDHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the 30-day timeframe to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. TDHS will not accept a request for extension of the thirty (30) day timeframe submitted by a family member, advocate, provider, or CMHC acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his/her whereabouts is unknown. All requests for good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if TDHS determines that a health, mental health or learning problem or disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to TDHS prior to termination of Medicaid eligibility and TDHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of TDHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of TDHS’s decision to grant the good cause extension. TDHS will send enrollees a letter

granting or denying the request for good cause extensions. TDHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to TDHS to determine his/her eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, TDHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day timeframe for responding to the Verification Request.

6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by TDHS shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories.

7. TDHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. Once the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by TDHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by TDHS but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while TDHS reviews their eligibility for open Medicaid categories. If TDHS makes a determination that the enrollee is eligible for an open Medicaid category, TDHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. Once the enrollee is enrolled in the appropriate TennCare Medicaid category, his/her eligibility as a non-pregnant Medically Needy adult shall then be terminated without additional notice. If TDHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

9. Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. TDHS shall review all such information pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage. The individual shall not be entitled to be reinstated into TennCare pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, s/he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy

pregnant women and children, to the latter of (a) the date of his or her application or (b) the date spenddown eligibility is met.

(c) Termination Notice

1. The TennCare Bureau will send Termination Notices to all non-pregnant adult Medically Needy enrollees being terminated pursuant to the TennCare Medicaid eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subsection.

2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

4. Enrollees with a health, mental health, or learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.

Statutory Authority: T.C.A. 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 3rd day of June, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 15th day of November, 2005.