Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-14
TennCare Standard

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 TennCare Standard adults aged nineteen (19) and older. The amendment also provides clarification of the TennCare Enrollee Cost Sharing poverty level percentages.

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.

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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 1200-13-14
TennCare Standard

Amendment

Rule 1200-13-14-.01 Definitions is amended by adding new paragraphs (69) and (106) and renumbering current paragraph (69) as (70) and (106) as (107) and renumbering subsequent paragraphs accordingly so as amended new paragraphs (69) and (106) 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.

(106) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged 19 and older in TennCare Standard eligibility groups.

Rule 1200-13-14-.02 Eligibility paragraph (3) is amended by adding subparagraph (h) which shall read as follows:

(h) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything else in these rules to the contrary.

Rule 1200-13-14-.02 Eligibility paragraph (4) is amended by adding subparagraph (a) which shall read as follows:

(a) Effective July 6, 2005, all TennCare Standard eligibility groups for adults aged nineteen (19) and older are terminated, notwithstanding anything else in these rules to the contrary.

Rule 1200-13-14-.02 Eligibility paragraph (5) is amended by adding subparagraph (t) which shall read as follows:

(t) The individual who is eligible for TennCare Standard in accordance with paragraphs (3) and (4) of this section is found to meet the following criteria:

1. S/he is aged nineteen (19) or older,

2. His/her eligibility category has been terminated from TennCare, and

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

Rule 1200-13-14-.02 Eligibility is amended by deleting paragraph (7) in its entirety and renumbering subsequent paragraphs accordingly.

Rule 1200-13-14-.02 Eligibility is amended by adding a new renumbered paragraph (9) which shall read as follows:

(9) Disenrollment Related to TennCare Standard Eligibility Reforms

Prior to the disenrollment of TennCare Standard enrollees based on coverage terminations resulting from TennCare Standard Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following.

(a) Ex Parte Review

TDHS will conduct an ex parte review of eligibility for open Medicaid categories for all TennCare Standard enrollees in eligibility groups due to be terminated as part of the TennCare Standard 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 TennCare Standard enrollees in eligibility groups being terminated pursuant to the TennCare Standard 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 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 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 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 thirty (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 are unknown. All requests for good cause extension must be made prior to termination of TennCare 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 DHS prior to termination of TennCare 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 Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard 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 appropriate TennCare Medicaid category. Once the enrollee is enrolled in TennCare Medicaid, his/her TennCare Standard eligibility 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. TDHS shall, pursuant to the rules, policies and procedures of TDHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by TDHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard 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 TennCare Standard enrollees being terminated pursuant to the TennCare Standard 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 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.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (1) subparagraph (b) is amended by revising the first two columns in the "Percentage of Poverty" section from "0%-100%" and "101%-149%" to "0%-99%" and "100%-149%" respectively so as amended subparagraph (b) shall read as follows:

(b) Effective January 1, 2002, the Bureau will update its Premium Sliding Scale Schedule monthly income brackets used for the determination of enrollee cost sharing to reflect the most current poverty levels as published by the Centers for Medicare and Medicaid Services. The Premium Sliding Scale effective January 1, 2002, follows:

Individual Monthly Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Monthly Premium	$0	$40.00	$70.00	$250.00	$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Monthly Premium	$500.00	$625.00	$875.00	$1,125.00	$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) is amended by adding the phrase "is equal to or" between the words "income" and "exceeds" in the first sentence and by deleting references to deductibles and 2% copayments which are no longer applicable so as amended paragraph (3) shall read as follows:

(3) In accordance with the following schedules, families and individuals who enroll in TennCare who are not Medicaid-eligible and whose income is equal to or exceeds 100% of the poverty level shall pay copayments for services other than preventive services.

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) subparagraph (a) is amended by revising the first two Poverty Levels in the chart from "0%-100%" and "101%-199%" to "0%-99%" and "100%-199%" respectively and by deleting the reference to the TennCare deductible so as amended subparagraph (a) shall read as follows:

(a) Effective January 1, 2000, or at such date thereafter as the change is approved by the Health Care Financing Administration and can be implemented, the annual TennCare Maximum Out-of-Pocket Expenditures described below shall apply for both uninsured and uninsurable designations, based on the poverty level.

TennCare Maximum Annual Out-of-Pocket Expenditures.

POVERTY LEVELS	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0% - 99%	$ 0.00	$ 0.00
100% - 199%	$ 1,000.00	$ 2,000.00
200% and above	$ 2,000.00	$ 4,000.00

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

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (3) subparagraph (b) is amended by revising the first two Poverty Levels in the chart from "0%-100%" and "101%-199%" to "0%-99%" and "100%-199%" respectively so as amended subparagraph (b) shall read as follows:

(b) Effective January 1, 2000, or at such date thereafter as the change is approved by the CMS and can be implemented, the following TennCare copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level. Effective August 1, 2002 the poverty levels will be those as used by TDHS.

TennCare Copayment Amounts.

POVERTY LEVELS	COPAYMENT AMOUNTS
0% - 99%	$ 0.00
100% - 199%	$ 25.00 for hospital emergency room (waived if admitted) $ 5.00 for primary care provider and Community Mental Health Agency services other than preventive care $ 15.00 for physician specialists $ 5.00 for prescription or refill $ 100.00 per inpatient hospital admission
200% and above	$ 50.00 for hospital emergency room (waived if admitted) $ 10.00 for primary care provider and Community Mental Health Agency services other than preventive care $ 25.00 for physician specialists $ 10.00 for prescription or refill $ 200.00 per inpatient hospital admission

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

Rule 1200-13-14-.05 Enrollee Cost Sharing paragraph (4) subparagraph (a) is amended by revising the first two column in the "Percentage of Poverty" section from "0%-100%" and "101%-149%" to "0%-99%" and "100%-149%" respectively so as amended subparagraph (a) shall read as follows:

(a) The following premiums were effective January 1, 2002 as approved by the Centers for Medicare and Medicaid Services, and apply to the TennCare Standard enrollees who are classified as uninsured or medically eligible.

Individual Monthly Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Monthly Premium	$0	$40.00	$70.00	$250.00	$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Monthly	$500.00	$625.00	$875.00	$1,125.00	$1,375.00

Premium					
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over

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.