Rulemaking Hearing Rules
of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-14
TennCare Standard

Amendments

Public necessity paragraphs (69) and (107) of rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with rulemaking hearing paragraphs (69) and (107) which 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.

(107) 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.

Statutory Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

Public necessity subparagraph (h) of paragraph (3) of rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with rulemaking hearing 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 in these rules to the contrary.

Public necessity subparagraph (a) of paragraph (4) of rule 1200-13-14-.02 Eligibility is replaced by rulemaking hearing 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 in these rules to the contrary.

Public necessity subparagraph (t) of paragraph (5) of rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with rulemaking hearing 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.

Public necessity rule 1200-13-14-.02 Eligibility which deleted paragraph (7) in its entirety is replaced by rulemaking hearing rule that deletes paragraph (7) in its entirety.

Public necessity paragraph (9) of rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with rulemaking hearing 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, 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 time frame 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, learning problem, 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 thirty (30) day time frame 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 time frame 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, learning problem, 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 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 the enrollee a letter granting or denying the request for good cause extension. 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 time frame 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 the appropriate TennCare Medicaid category. When the enrollee is enrolled in the TennCare Medicaid, his/her TennCare Standard eligibility shall 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 spend down 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 will inform enrollees how they may request a hearing.

4. Enrollees with a health, mental health, 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 time frame in which to request a hearing.

Public necessity subparagraph (b) of paragraph (1) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with rulemaking hearing subparagraph (b) which 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

Public necessity paragraph (3) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with rulemaking hearing paragraph (3) which 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.

Public necessity subparagraph (a) of paragraph (3) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with rulemaking hearing subparagraph (a) which shall read as follows:

(a) Effective January 1, 2000, or at such date thereafter as the change is approved by the Centers for Medicare and Medicaid Services 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. Effective August 1, 2005, there is no Out of Pocket Maximum for enrollee copays.

Public necessity subparagraph (b) of paragraph (3) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with rulemaking hearing subparagraph (b) which shall read as follows:

(b) Copayments.

1. 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.

2. Effective August 1, 2005, the copayment amounts for pharmacy services for persons at or above 100% poverty is $3.00 per branded drug.

Public necessity subparagraph (a) of paragraph (4) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with rulemaking hearing subparagraph (a) which 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 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

Statutory Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

The rulemaking hearing rules set out herein were properly filed in the Department of State on the 1st day of September, 2005 and will become effective on the 15th day of November, 2005.