Rulemaking Hearing Rules
of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-14
TennCare Standard

Amendments

Public necessity subparagraph (a), (b), (d), (e), and (f) of paragraph (7) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in their entirety and replaced with rulemaking hearing subparagraphs (a), (b), (d), (e), and (f) which shall read as follows:

(a) For enrollees in families with incomes equal to or above two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is two thousand ($2,000) dollars per individual and four thousand ($4,000) dollars per family. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

(b) For enrollees in families with incomes below two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is one thousand ($1,000) dollars per individual and two thousand ($2,000) dollars per family. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

(d) Effective August 1, 2002, the poverty levels for out-of-pocket maximum will be the poverty levels used by the Tennessee Department of Human Services. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

(e) Effective January 1, 2003, included in the annual out-of-pocket maximums are monthly out-of-pocket maximums for pharmacy services only. The monthly out-of-pocket maximum for pharmacy services for all TennCare Standard enrollees is one hundred-fifty ($150.00) dollars per enrollee per month. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

(f) TennCare Standard enrollees are responsible for requesting a review of his/her out-of-pocket expenditures by TennCare if s/he believes s/he has reached, or is close to reaching, his/her out-of-pocket maximum. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

Public necessity subparagraphs (l), (m), and (n) of paragraph (7) of rule 1200-13-14-.05 is deleted in their entirety and replaced with rulemaking hearing subparagraphs (l), (m), and (n) which shall read as follows:

(l) Pharmacy and Psychiatric Pharmacy Copayments

1. Effective August 1, 2005, all TennCare Standard enrollees with incomes at or above poverty who receive pharmacy services will have nominal copayments on these services. The copays will be $3.00 for each branded drug and $0 for each covered generic drug. Generic drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay.

2. The following groups (adults and children) are exempt from copay:

(i) Individuals receiving hospice services who provide verbal notification of such to the provider at the point of service;

(ii) Individuals who are pregnant who provide verbal notification of such to the provider at the point of service; and

(iii) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.

(m) Effective August 1, 2005, there is no maximum out-of-pocket maximum on pharmacy services.

(n) The three (3) day supply requirements of the *Grier Revised Consent Decree* do not affect the pharmacy copay requirements. Every prescription for all TennCare Standard enrollees will require a copayment as described herein. In the event the three (3) day supply represents less than a full prescription, the entire copayment will be required.

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 26th day of September, 2005 and will become effective on the 10th day of December, 2005.