

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.

The Commissioner is authorized to promulgate public necessity rules and regulations to “comply with or to implement the provisions of any federal waiver” permitted under the TennCare Medical Assistance Program (T.C.A. §§ 71-5-101 71-5-134. Further, the Bureau is authorized to promulgate public necessity rules when required by an agency of the federal government and adoption of the rule through ordinary rulemaking procedures might jeopardize the loss of federal funds. T.C.A. §4-5-209(a)(3).

The Enrollee Cost Sharing rules of TennCare Standard do not conform to the terms of the Demonstration Waiver approved by CMS. In order for the rules to reflect the authority granted by CMS, the Bureau of TennCare hereby proceeds pursuant to T.C.A. §§ 71-5-134 and 4-5-209(a)(3) to adopt these public necessity rules.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

Darin J. Gordon
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

Amendments

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (27). The current paragraph (27) will be renumbered as (28) and subsequent paragraphs will be renumbered accordingly so as amended the new paragraph (27) shall read as follows:

- (27) DEMAND LETTER shall mean a letter sent by TennCare to a TennCare Standard enrollee with premium obligations notifying the enrollee that he is at least 60 days delinquent in his premium payments.

Paragraph (22) (Cost Sharing) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new paragraph (22) which shall read as follows:

- (22) COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes premiums and/or copayments.

Paragraph (109) (TennCare Standard) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new paragraph (109) which shall read as follows:

- (109) TENNCARE STANDARD shall mean that part of the TennCare Program which provides coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules.

Rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with a new rule 1200-13-14-.05 which shall read as follows:

1200-13-14-.05 Enrollee Cost Sharing.

- (1) Persons who are enrolled in TennCare Standard have premium obligations corresponding to their family size and income. The premium schedule is shown below:

Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Monthly Premium (Individual)	\$0	\$20	\$35	\$100	\$150
Monthly Premium (Family of 2 or more)	\$0	\$40	\$70	\$250	\$375

Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% and over
Monthly Premium (Individual)	\$200	\$250	\$350	\$450	\$550
Monthly Premium (Family of 2 or more)	\$500	\$625	\$875	\$1,125	\$1,375

(2) Premium requirements.

- (a) Individuals determined eligible for TennCare and who are required to pay premiums will be sent a notice indicating the amount of the premium. Premium payments are due on the first day of each month.
- (b) Monthly premium statements are sent to enrollees with premium obligations. If the enrollee is delinquent in his payments, the monthly premium statements will so advise him.
- (c) At such time as (1) the enrollee has received at least two premium statements advising him of his arrearage AND (2) he is 60 days in arrears on his premium payments, coverage may be terminated for non-payment of premiums.
 - 1. Enrollees who are in arrears two months in premium payments will be sent a notice of delinquency (a "demand letter"). The notice will identify the specific payments, including month and amount, that are past due. The demand letter will serve as notice to the individual that he will be terminated from TennCare Standard unless he pays the amount due within 30 days. The enrollee has the right to appeal that he is in fact current with his payments or that the premium amounts being charged are not the premium amounts he has been assigned.
 - 2. If at least partial payment is received by the Bureau of TennCare within 30 days after the date of the demand letter, the enrollee will no longer be 60 days in arrears, and coverage will continue without interruption. "Partial payment" will be payment sufficient to make the enrollee no longer 60 days in arrears. However, remaining past due amounts will continue to accrue. If the enrollee is again 60 days in arrears when the next cycle of demand letters is processed, the enrollee will again receive a demand letter and may subsequently be terminated in accordance with these rules.
 - 3. If an enrollee files an appeal in response to his demand letter by the 30th day following the date of the notice, coverage will not be terminated on the 30th day, pending resolution of the appeal. The premium appeal will be processed by DHS in accordance with its rules at 1240-5.
 - 4. If the enrollee does not pay at least a partial payment or file an appeal by the 30th day following the demand letter, his TennCare Standard coverage will be terminated. A termination notice will be sent with

due process appeal rights. The date of termination is the date of the termination notice. An enrollee may appeal his notice of termination, but he is not entitled to continuation of benefits during the appeal. If the appeal is decided in his favor, he will be reinstated retroactively to the date of termination.

- (3) There are no deductibles or out-of-pocket maximums in TennCare Standard.
- (4) Copayments.
 - (a) TennCare Standard enrollees whose income is equal to or greater than 100% of poverty shall pay copayments for services other than preventive services. Preventive services are identified in Rule 1200-13-14-.04(2).
 - (b) Copayment amounts are as shown below:

Benefit	Copayment if income is 0%-99% of poverty	Copayment if income is 100%-199% of poverty	Copayment if income is 200% of poverty or above
Hospital emergency room use for non-emergency services_	\$0	\$25 (waived if admitted)	\$50 (waived if admitted)
Primary care provider services other than preventive care	\$0	\$5	\$10
Community Mental Health Agency services other than preventive care	\$0	\$5	\$10
Physician specialists	\$0	\$15	\$25
Prescription or refill (see (f) below)	\$0	\$3 for covered branded prescription; \$0 for covered generics	\$3 for covered branded prescription; \$0 for covered generics
Inpatient hospital admission	\$0	\$100	\$200

- (c) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this paragraph.
- (d) Providers may not refuse to deliver a covered service to an enrollee because of the enrollee's failure or inability to make his copay.
- (e) Enrollees who receive financial settlements, awards or judgments shall have their income levels adjusted retroactively to the date of the incident resulting in the settlement or other payment, and may be assessed additional cost sharing obligations commensurate with their adjusted income level retroactive to that date.

- (f) Pharmacy and psychiatric pharmacy copayments.
1. All TennCare Standard enrollees with incomes at or above poverty who receive pharmacy services have nominal copayments for the services. The copays are \$3.00 for each covered branded drug and \$0 for each covered generic drug. Drugs which exceed the limit of five (5) prescriptions or refills per month per enrollee are not covered unless they are on the Automatic Exception List. Family planning drugs and emergency services are exempt from copay.
 2. The following groups (adults and children) are exempt from pharmacy copays:
 - (i) Individuals receiving hospice services who provide verbal or written notification of such to the pharmacy provider at the point of service;
 - (ii) Individuals who are pregnant who provide verbal or written notification of such to the pharmacy 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.
 3. The seventy-two (72) hour emergency supply of a medication in an emergency situation, as described in rule 1200-13-14-.11, shall not be subject to the pharmacy copayment requirement.

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 21st day of March, 2007, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 2nd day of September, 2007. (FS 03-22-07, DBID 2464)