RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-03-01
GENERAL RULES

TABLE OF CONTENTS

1240-03-01-.01 NECESSITY AND FUNCTION. The Department of Human Services has responsibility to determine eligibility for medical assistance in accordance with Title XIX of the Social Security Act and Federal regulations. T.C.A. § 71-5-102 empowers the Department to comply with any requirement that may be imposed or opportunity presented by Federal law for the provision of medical assistance to Tennessee's indigent citizenry. Federal regulations set forth definitions for words and/or phrases used by the Department in policies pertaining to the provision of medical assistance. [42 C.F.R. § 435.4].

Authority: *TCA §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-109 and 71-5-111; 42 U.S.C. §§ 1396 et seq.; and 42 C.F.R. § 435.4.* ***Administrative History:*** *Original rule filed June 14, 1976; effective July 14, 1976. Amendment filed June 9, 1981; effective October 5, 1981. Amendment filed April 22, 2008; effective July 6, 2008.*

1240-03-01-.02 DEFINITIONS.

(1) Definitions of terms or phrases utilized in regulations relating to the Medical Assistance Program are as follows:

(a) Aid to Families with Dependent Children (AFDC). Refers to the name of the cash assistance program for Families and Children prior to the passage of the Welfare Reform Act in July 1996.

(b) Aid to Families with Dependent Children – Medicaid Only (AFDC-MO (Section 1931)). Refers to Section 1931 of the Social Security Act [42 U.S.C. § 1396u-1] which requires that any family group that qualifies for Medicaid based on AFDC-MO regulations prior to July 16, 1996 be tested for eligibility in this group.

(c) Bureau of TennCare (herein referred to as "TennCare" or as "Bureau"). The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare Program. For the purposes of these rules, the Bureau of TennCare shall represent the State of Tennessee and its representatives.

(d) Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A Caretaker relative may be included in the AFDC-MO Category if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA § 71-3-153]

(Rule 1240-03-01-.02, continued)

(e) Categorically Needy. Categorically Needy individuals are entitled to the broadest scope of medical assistance benefits. All recipients of Medicaid based on Section 1931-AFDC-MO and the SSI program for the aged, blind or disabled are Categorically Needy. In addition, many adults, families, pregnant women and children who do not receive cash assistance receive the Categorically Needy level of benefits for Medicaid Only assistance.

(f) CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility (NF) level of care criteria, who could have been eligible for Home and Community Based Services (HCBS) under 42 C.F.R. § 435.217 had the state continued its 1915(c) HCBS Waiver for persons who are elderly and/or physically disabled, and who need and are receiving HCBS as an alternative to NF care. This group exists only in the Grand Divisions of Tennessee where the CHOICES Program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

(g) CHOICES Group 1. Individuals of all ages who are receiving Medicaid-reimbursed care in a NF.

(h) CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility level of care and who qualify for TennCare either as SSI recipients or as in an institutional category (i.e., as members of the CHOICES 217-Like demonstration population), and who need and are receiving HCBS as an alternative to NF care. TennCare has the discretion to apply an enrollment target to this group.

(i) CHOICES Member. An individual who has been enrolled by the Bureau of TennCare into the CHOICES Program.

(j) Code of Federal Regulations (C.F.R.). Federal regulations which transfer to regulatory form the specific requirements of Federal law.

(k) Co-insurance. Coinsurance amounts payable by the recipient under the provisions of Title XVIII, Part B for covered medical services rendered under the Medicare Program and becoming due after satisfaction of the deductible liability. [42 U.S.C. §§ 1395j et seq.]

(l) Deductible. Amounts payable by the recipient which fall within an aged beneficiary's deductible liability imposed by Title XVIII, Part B. Health Insurance for the Aged. [42 U.S.C. §§ 1395j et seq.]

(m) Eligible individual. A person who has applied for medical assistance and has been found to meet all applicable conditions for eligibility pertaining to Tennessee's Medical Assistance Program.

(n) Enrollment Target. The maximum number of individuals that can be enrolled in CHOICES Group 2 at any given time, subject to exceptions defined by the Bureau of TennCare. The enrollment target is not calculated on the basis of "unduplicated participants." Vacated slots in CHOICES Group 2 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS waiver programs.

(o) Excess income. That portion of the income of the individual or family group, which exceeds amounts allowable to the individual or family group as disregarded income or income protected for basic maintenance and which results in a determination of ineligibility.

(Rule 1240-03-01-.02, continued)

1. Excess Resources. That portion of the liquid assets or other resources of the individual or family group in excess of the amounts which may be retained for the individual or family group's security and personal use, not exempted from consideration or otherwise accounted for by special specified circumstances, and which result in a determination of ineligibility.

2. Spenddown. The process by which excess income is utilized for recognized medical expenses and which, when depleted, results in a determination of eligibility if all other eligibility factors are met.

(p) Families First (FF). Tennessee's TANF program (Temporary Assistance for Needy Families) which provides cash assistance to families with dependent children. [42 U.S.C. §§ 601 et seq.]

(q) Inpatient services. Those services rendered for any acute or chronic condition, including maternal and mental health care, which cannot be rendered on an outpatient basis.

(r) Joint Custody. Legal custody of a child held simultaneously by two (2) or more caretaker relatives. The caretaker relatives must exercise care and control of the child.

(s) Level 1 Nursing Facility care. The level of Medicaid reimbursement provided for nursing facility services delivered to residents eligible for Medicaid-reimbursement of NF services determined by TennCare to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(4) by a NF that meets the requirements set forth in Rule 1200-13-01-.03, and in accordance with the reimbursement methodology for Level 1 NF Care set forth in Rule 1200-13-01-.03.

(t) Level 2 Nursing Facility care. The level of Medicaid reimbursement provided for nursing facility services delivered to residents eligible for Medicaid-reimbursement of NF services determined by TennCare to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5) by a NF that meets the requirements set forth in Rule 1200-13-01-.03, and in accordance with the reimbursement methodology for Level 2 NF Care set forth in Rule 1200-13-01-.03.

(u) Long-Term Care Program. One of the programs offering long-term care services to individuals enrolled in TennCare. Long-Term Care Programs include institutional programs (NFs and ICFs/MR), as well as HCBS offered either through the CHOICES Program or through a section 1915(c) HCBS waiver program.

(v) Medicaid. The State program of medical assistance as administered by the Department in compliance with Title XIX of the Social Security Act [42 U.S.C. §§ 1396 et seq.] and which is designed to provide for the medical care needs of Tennessee's medically indigent citizenry.

(w) Medical assistance drug list. A listing of drugs covered under the Medical Assistance Program, which includes the drug code, description, dosage strength, covered unit form, maximum dosage covered, and per unit price.

(x) Medically Needy. Individuals whose income or resources are under a certain limit and allows them to qualify for Medicaid by spending down their medical expenses.

(y) Medicare. The Federal program under Title XVIII of the Social Security Act [42 U.S.C. §§ 1395 et seq.] providing medical benefits to persons receiving Social Security

(Rule 1240-03-01-.02, continued)

Retirement payments or who have received Social Security benefits based on disability for a period of twenty-four (24) consecutive months.

1. Part A of Title XVIII. Hospital Insurance Benefits provides hospital care, nursing home care, and home health visits, subject to deductibles and co-insurance. [42 U.S.C. § 1395c]

2. Part B of Title XVIII. Supplementary Medical Insurance provides additional medical benefits to those persons eligible for Part A or any person sixty-five (65) years of age, but only if enrolled in the program and paying the monthly premium. [42 U.S.C. § 1395j]

(z) Medicare Savings Program. The mechanisms by which low-income Medicare beneficiaries can get assistance from Medicaid in paying for their Medicare premiums, deductibles, and/or coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.

(aa) Nursing Facility (NF). A Medicaid-certified NF approved by the Bureau of TennCare.

(bb) Outpatient services. Services provided, in other than inpatient circumstances, for any condition detrimental to the individual recipient's physical or mental health which cannot be taken care of in the home situation.

(cc) Patient Liability. The amount determined by DHS which a Medicaid Eligible is required to pay for covered services provided by a NF, an ICF/MR, an HCBS waiver program, or the CHOICES Program.

(dd) Program of All-Inclusive Care for the Elderly (PACE). A program for dually eligible enrollees in need of long-term care services that is authorized under the Medicaid State Plan, Attachment 3.1-A, #26.

(ee) Poverty Groups. Assistance groups whose gross income does not exceed various percentages of the Federal Poverty Level Income Standard.

(ff) Qualified Disabled and Working Individual (QDWI). A person who is under age sixty-five (65) who has lost their Medicare Part A coverage because they returned to work, despite their disability, and have an option to purchase Medicare Part A for an indefinite period and for whom Medicaid pays the Medicare Part A, if income is not more than two hundred percent (200%) of the federal poverty level and resources are not more than twice the SSI limit ($4,000 for an individual, $6,000 for a couple) and is not otherwise eligible for Medicaid.

(gg) Qualified Long Term Care Insurance Policy. A long term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to State Rule 0780-01-61 as:

1. A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

2. A policy that has been issued in another Partnership state and which is covered under a reciprocal agreement between such other state and the State of Tennessee.

(hh) Qualified Medicare Beneficiary (QMB). A person who is eligible for Medicare Part A and for whom Medicaid pays the Medicare premium, coinsurance and deductible for

(Rule 1240-03-01-.02, continued)

Medicare covered services and whose income is not more than one hundred percent (100%) of the federal poverty level and resources are not more than twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple). Effective beginning with January 1, 2010, the resource limit is $6,600 for an individual and $9,910 for a couple.

(ii) Qualifying Individual 1 (QI1) (also referred to as a Specified Low-Income Beneficiary (SLIB)). A person who is eligible on a "first come, first served basis" for Medicaid to pay the Medicare Part B premium, if the individual is eligible to receive Part A Medicare, is not otherwise eligible for Medicaid and income is not more than one hundred thirty-five percent (135%) of the federal poverty level and resources are not more than twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple). Effective beginning with January 1, 2010, the resource limit is $6,600 for an individual and $9,910 for a couple.

(jj) Services. In addition to services related to eligibility for program benefits, services to applicants and recipients shall also include the release of information from program files that is deemed necessary to protect the safety and / or well-being of the applicant / recipient, in the event that the applicant / recipient is reasonably considered to be a danger to him / herself or others based on information provided by the applicant / recipient or his / her household or assistance group. The release of information in these circumstances shall be considered integral to the administration of the program.

(kk) Specified Low-Income Medicare Beneficiary (SLMB). A person who is eligible for Medicare Part A and for whom Medicaid pays Medicare Part B premiums, if income is not more than one hundred twenty percent (120%) of the federal poverty level and resources are not more than twice the SSI limit ($4,000 for an individual, $6,000 for a couple). Effective beginning with January 1, 2010, the resource limit is $6,600 for an individual and $9,910 for a couple.

(ll) Statewide E/D Waiver. The Section 1915(c) HCBS Waiver project approved for Tennessee by the Centers for Medicare and Medicaid Services (CMS) to provide services to a specified number of Medicaid-eligible adults who reside in Tennessee, who are aged or have physical disabilities, and who meet the medical eligibility (or level of care) criteria for reimbursement of Level 1 NF services.

(mm) Supplemental Security Income (SSI). A federal income supplement program funded by general tax revenues and is designed to help aged, blind and disabled individuals who have little or no income. Applications for SSI benefits are filed at the Social Security office. Individuals who are eligible for SSI are automatically entitled to Medicaid. [42 U.S.C. §§ 1382 et seq.]

(nn) Temporary Assistance for Needy Families (TANF). Program which was created by the Welfare Reform Law of 1996. TANF became effective July 1996 and replaced what was then commonly known as the AFDC program. [42 U.S.C. §§ 601 et seq.]

(oo) TennCare CHOICES in Long-Term Care (called "CHOICES"). The program in which NF services for TennCare eligibles and HCBS for individuals aged sixty-five (65) and older and/or adults aged twenty-one (21) and older with physical disabilities are integrated into TennCare’s managed care delivery system.

(2) Definitions of terms or phrases utilized in Medicaid Spenddown, Standard Spend Down and TennCare Standard.

(Rule 1240-03-01-.02, continued)

(a) Call-in Line. The toll-free telephone single point of entry used during a period of open enrollment (as announced by the Bureau of TennCare) to enroll new applicants in the Standard Spend Down Program (SSD).

(b) Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A caretaker relative may be considered for SSD if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA §71-3-153]

(c) Continuous eligibility. Enrollment in a Medicaid Medically Needy, Standard Spend Down or TennCare Standard eligibility category with no break in coverage.

(d) Continuous enrollment. Certain individuals determined eligible for the TennCare Program may enroll at any time during the year. Continuous enrollment is limited to persons in the following two (2) groups:

1. TennCare Medicaid enrollees; or

2. Individuals who are losing their Medicaid, who are uninsured, who are under 19 years of age, and who meet the qualifications for TennCare Standard as “Medicaid Rollovers” in accordance with the provisions of these rules.

(e) Open enrollment. A designated period of time determined by the Bureau of TennCare, during which individuals may apply for enrollment in TennCare Standard or Standard Spend Down.

1. The following individuals may apply for TennCare Standard as uninsured or medically eligible persons during a period of open enrollment:

(i) Uninsured individuals whose incomes fall within the poverty levels established for the period of open enrollment being held;

(ii) Individuals qualifying as medically eligible as defined in these rules and whose incomes fall within the poverty levels established for the period of open enrollment being held.

2. Individuals applying for the Standard Spend Down Program may apply during a period of open enrollment announced by the Bureau of TennCare in accordance with these rules.

(f) Standard Spend Down. The demonstration category composed of adults aged twenty-one (21) and older who are not eligible for Medicaid but who meet the requirements for Standard Spend Down that are outlined in these rules and those of the TennCare Bureau.

(g) TennCare Standard. 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 and those of the TennCare Bureau.

(Rule 1240-03-01-.02, continued)

(h) Transition Group. Existing Medicaid Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults twenty-one (21) or older.

Authority: *T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105, 71-1-105(12), 71-3-153, 71-3-158(d)(2)(D), 71-5-101, 71-5-103, 71-5-111, and 71-5-1401 et seq.; Acts 2007, Ch 31, § 11; Acts 2008, Chapter 1190, 42 U.S.C. § 423, 42 U.S.C. §§ 601 et seq.; 42 U.S.C. §§ 1382 et seq.; 42 U.S.C. § 1382(b), 42 U.S.C. §§ 1395 et seq.; 42 U.S.C. § 1395i-2a] 42 U.S.C. § 1395w-114(a)(3)(D), 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(E); 42 U.S.C. § 1396a(e)(4); 42 U.S.C. § 1396d(p)(1), (2) and (3), 42 U.S.C. § 1396d(p)(1)(C), 42 U.S.C. § 1396d(s); 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5), 42 U.S.C. § 1396r and 42 U.S.C. § 1396u-1; 42 C.F.R. § 431.302, 42 C.F.R. § 435.4; 45 C.F.R. § 233.90(c); PL 101-508 § 5103(e); PL 98-21 § 134, PL 100-203 § 9116, PL 104-193, and PL 109-171 § 6021; PL 110-275, Title I, § 112, TennCare II Medicaid Section 1115 Demonstration Waiver and Acts 2008, Chapter 1190.* ***Administrative History:*** *Original rule filed June 14, 1976; effective July 14, 1976. Amendment filed April 23, 1997; effective July 7, 1997. Public necessity rule filed July 2, 2007; effective through December 14, 2007. Amendment filed September 25, 2007; effective December 9, 2007. Public necessity rule filed January 24, 2008; effective through July 7, 2008. Amendment filed April 22, 2008; effective July 6, 2008. Amendment filed February 24, 2009; effective May 10, 2009. Amendment filed August 5, 2009; effective November 3, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 25, 2010; effective August 23, 2010. Amendment filed July 21, 2010; to have been effective October 19, 2010; a two day stay of effective date was filed September 20, 2010 by the Tennessee Department of Human Services; new effective date October 21, 2010.*