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Revision Type (check all that apply):

- ☒ Amendments
☐ New
☐ Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables. Please enter only **ONE Rule Number/RuleTitle per row)**

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	Rule Title
1200-13-14-.01	Definitions
1200-13-14-.02	Eligibility
1200-13-14-.03	Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCs)
1200-13-14-.04	Covered Services
1200-13-14-.05	Enrollee Cost Sharing
1200-13-14-.06	Managed Care Organizations
1200-13-14-.08	Providers
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(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

Chapter 1200-13-14
TennCare Standard

Emergency Rule Paragraph (6) Benefits of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (6) which shall read as follows:

- (6) Benefits shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees. Additional benefits are available through the TennCare CHOICES program, as described in Rule 1200-13-01-.05. CHOICES benefits are available only to persons who qualify for and are enrolled in the CHOICES program.

Emergency Rule Paragraphs (13), (14), (15), and (16) of Rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraphs (13), (14), (15), and (16) which shall read as follows:

- (13) CHOICES. See "TennCare CHOICES in Long-Term Care."
(14) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.
(15) CHOICES Group 1. See definition in Rule 1200-13-01-.02.
(16) CHOICES Group 2. See definition in Rule 1200-13-01-.02.

Emergency Rule Paragraph (25) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a Rulemaking Hearing Rule Paragraph (25) which shall read as follows:

- (25) Contract Provider shall have the same meaning as Participating Provider.

Emergency Rule Paragraph (30) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (30) which shall read as follows:

- (30) 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 copayments.

Emergency Rule Paragraph (31) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (31) which shall read as follows:

- (31) Covered Services shall mean the services and benefits that:
- (a) TennCare contracted MCCs cover, as set out elsewhere in this Chapter and in Rule 1200-13-01-.05; or
 - (b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1915(c) of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

Emergency Rule Paragraph (62) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (62) which shall read as follows:

- (62) In-Network Provider shall have the same meaning as Participating Provider.

Emergency Rule Paragraph (68) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (68) which shall read as follows:

- (68) Long-Term Care shall mean programs and services described under Rule 1200-13-01-.01.

Emergency Rule Paragraph (70) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with rulemaking hearing Rule Paragraph (70) which shall read as follows:

- (70) MCO (Managed Care Organization) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program.

Emergency Rule Paragraphs (82), (83), and (84) of Rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraphs (82), (83), and (84) which shall read as follows:

- (82) Non-Contract Provider shall have the same meaning as Non-Participating Provider.
- (83) Non-Participating Provider shall mean a TennCare provider, as defined in this Rule, who is not contracted with a particular enrollee's MCO. This term may include TennCare providers who furnish services outside the managed care program on a fee-for-service basis, as well as TennCare providers who receive Medicare crossover payments from TennCare.
- (84) Non-TennCare Provider shall mean a provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

Emergency Rule Paragraphs (87) and (88) of Rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraphs (87) and (88) which shall read as follows:

- (87) Out-of-Network Provider shall have the same meaning as Non-Participating Provider.
- (88) Out-of-State Emergency Provider shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he must abide by all TennCare rules and regulations, including those concerning provider billing of enrollees as found in Rule 1200-13-14-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, and they must not be excluded from participation in Medicare or Medicaid.

Emergency Rule Paragraph (90) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (90) which shall read as follows:

- (90) Participating Provider shall mean a TennCare provider, as defined in this Rule, who has entered into a contract with an enrollee's Managed Care Contractor.

Emergency Rule Paragraph (100) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (100) which shall read as follows:

- (100) Provider shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:
 - (a) Participating Providers or In-Network Providers
 - (b) Non-Participating Providers or Out-of-Network Providers
 - (c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in this Rule.

Emergency Rule Paragraph (124) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (124) which shall read as follows:

(124) TennCare CHOICES in Long-Term Care shall mean the program described in Rule 1200-13-01-.05.

Emergency Rule Paragraph (128) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (128) which shall read as follows:

(128) TennCare Provider shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in this Rule, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including requirements regarding provider billing of patients as found in Rule 1200-13-14-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

- (b) The Bureau of TennCare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the TennCare Program. The Bureau is responsible for establishing policy and procedural requirements and criteria for TennCare.
 - 1. With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.
 - 2. With respect to the eligibility of individuals applying for the TennCare CHOICES program, the Bureau is responsible for determining that the individual meets level of care eligibility criteria for the long-term care services or reimbursement requested. For enrollment into CHOICES Group 2, the Bureau is also responsible for determining the state's ability to provide appropriate Home and Community Based Services (HCBS) as determined by the availability of slots under the established enrollment target in accordance with Rule 1200-13-01-.05 and for confirming a determination by an Area Agency on Aging and Disability or TennCare Managed Care Organization that:
 - (i) The individual is an adult aged sixty-five (65) or older, or an adult aged twenty-one (21) or older with physical disabilities; and
 - (ii) Such individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's cost neutrality cap pursuant to Rule 1200-13-01-.05.
 - 3. The Bureau is responsible for granting, at its discretion, immediate eligibility for persons applying for enrollment into CHOICES Group 2, pursuant to Rule 1200-13-01-.05.

Emergency Rule Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

- (b) Provide a statement from his employer, if employed, concerning the availability of group health insurance. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Emergency Rule Subparagraph (g) of Paragraph (3) of Rule 1200-13-14-.02 Eligibility which added the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph is replaced with Rulemaking Hearing Rule Subparagraph (g) which shall read as follows:

- (g) Not be eligible for or have purchased other health insurance as defined at Rule 1200-13-14-.01, except for persons in the category of uninsured children under the age of nineteen (19) whose family income is below two hundred percent (200%) of poverty and who have been continuously enrolled in

TennCare Standard since at least December 31, 2001. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Emergency Rule Subparagraph (h) of Paragraph (3) of Rule 1200-13-14-.02 Eligibility which added the phrase “or the CHOICES 217-Like Group” at the end of the Subparagraph is replaced by Rulemaking Hearing Rule Subparagraph (h) which shall read as follows:

- (h) Not be enrolled in, or eligible for participation in, Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Emergency Rule Paragraph (7) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (7) which shall read as follows:

(7) TennCare Standard: CHOICES 217-Like Group

- (a) Coverage 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 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 Nursing Facility (NF) care. This group exists only in the Grand Divisions of the state where the CHOICES program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.
- (b) Eligibility criteria:
 - 1. Must be aged sixty-five (65) and older or aged twenty-one (21) and older with physical disabilities as defined in Rule 1200-13-01-.02;
 - 2. Must meet the Nursing Facility level of care requirements;
 - 3. Must have a current determination by an Area Agency on Aging and Disability or the TennCare MCO to which the individual is assigned, that he is able to be safely and appropriately served in the community and within his individual cost neutrality cap as defined in Rule 1200-13-01-.05;
 - 4. May be enrolled in accordance with requirements pertaining to the enrollment target for CHOICES Group 2, as described in Rule 1200-13-01-.05;
 - 5. Will be enrolled and begin receiving Home and Community Based Services (HCBS) upon determination of financial eligibility by DHS and continue to receive HCBS as a CHOICES Group 2 participant. Qualifying for enrollment into CHOICES Group 2 (HCBS) is not sufficient to establish eligibility in the CHOICES 217-Like Group if the person will not actually be enrolled and receiving HCBS; and
 - 6. Would be eligible in the same manner as specified under 42 C.F.R. § 435.217, 435.236, and 435.726 and section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-d), if the Home and Community Based Services (HCBS) were provided under a section 1915(c) waiver.
- (c) Application procedures
 - 1. To be eligible for the CHOICES 217-Like Group, each individual must meet all technical and financial requirements applicable to this category as described in DHS Rule Chapter 1240-03-03.
 - 2. The effective date of eligibility in the CHOICES 217-Like Group shall be the date the application is approved by DHS unless TennCare has granted Immediate Eligibility pursuant to Rule 1200-13-01-.05(3)(f), in which case, the effective date of eligibility in the CHOICES 217-Like HCBS Group shall be the effective date of Immediate Eligibility granted by TennCare. In no instance shall the effective date of eligibility precede the date the application was filed with DHS.

The Emergency Rule introductory sentence to Paragraph (8) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory sentence which shall read as follows:

(8) Redetermination of eligibility in TennCare Standard (other than CHOICES 217-Like Group).

Emergency Rule Subparagraph (c) of Paragraph (8) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) Information to be recertified includes changes in address, income, employment, family size, and access to health insurance (access to insurance is not considered in determining eligibility in the Standard Spend Down category). Redetermination appointments must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice reminding the enrollee that he must have his eligibility redetermined will inform the enrollee of the documentation to be brought to the appointment.

Emergency Rule renumbered Paragraph (9) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (9) which shall read as follows:

(9) Redetermination of eligibility in the CHOICES 217-Like Group.

An enrollee who qualifies for TennCare through DHS shall have his TennCare eligibility redetermined by DHS as required by the appropriate category of medical assistance. Prior to termination, eligibility will be reviewed in accordance with the following process:

- (a) At least thirty (30) days prior to the expiration of his current eligibility period, the Bureau of TennCare will send a Request for Information to the enrollee. The Request for Information will include a form to be completed with information needed to verify continued eligibility in the CHOICES 217-Like Group.
- (b) 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 DHS and to provide DHS with the necessary verifications to determine continued eligibility for the CHOICES 217-Like Group.
- (c) Enrollees with a health problem, mental health problem, 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.
- (d) If an enrollee provides some but not all of the necessary information to DHS to verify his continued eligibility for the CHOICES 217-Like Group during the thirty (30) day period following the Request for Information, DHS 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.
- (e) Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare (subject to any changes in covered services generally applicable to enrollees in their eligibility category) while DHS reviews their eligibility in the CHOICES 217-Like Group.
- (f) Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare while DHS reviews their eligibility in the CHOICES 217-Like Group. If DHS determines that the enrollee remains eligible for his current CHOICES 217-Like category, the enrollee will remain enrolled in such category. If DHS makes a determination that the enrollee is not eligible for continued enrollment in the CHOICES 217-Like Group, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
- (g) Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage.

Renumbered Emergency Rules Subparagraphs (a), (b), (c), (d), (m), (n), (o) and Unnumbered Paragraph of Paragraph (10) of Rule 1200-13-14-.02 Eligibility is deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraph (10) which shall read as follows:

(10) Losing eligibility for TennCare Standard.

- (a) Eligibility for TennCare Standard shall cease when it has been determined that the enrollee, as the result of one of the following events, no longer meets the criteria for the program. Eligibility for TennCare Standard shall end if:
 - 1. The enrollee becomes eligible for participation in a group health insurance plan, as defined in this Chapter, either directly or indirectly through a family member. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);
 - 2. The enrollee becomes eligible for Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);
 - 3. The enrollee is determined eligible for Medicaid (this does not apply to the CHOICES 217-Like Group, unless the enrollee begins receiving SSI);
 - 4. The enrollee purchases an individual health insurance plan as defined by this Chapter. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);
 - 5. The enrollee fails to comply with TennCare Program requirements, subject to federal and state laws and regulations;
 - 6. The enrollee dies;
 - 7. It is determined that any of the technical eligibility requirements found in this Rule are no longer met;
 - 8. The enrollee has failed to respond to a redetermination process requirement, as described in this Rule, to assure that the enrollee and other family members, as appropriate, remain eligible for TennCare Standard;
 - 9. The enrollee sends a voluntary written request for termination of eligibility for TennCare Standard to the DHS county office in the county in which he resides;
 - 10. The enrollee no longer qualifies as a resident of Tennessee under federal and state law;
 - 11. The enrollee fails to complete the redetermination process within the timeframes specified within this Rule;
 - 12. The enrollee becomes incarcerated as an inmate;
 - 13. The Bureau determines that the enrollee does not actually have the medical condition(s) which rendered him "medically eligible" for TennCare Standard;
 - 14. The enrollee attains the age of nineteen (19) and has not been determined eligible in an open Medicaid category; or
 - 15. An enrollee in the CHOICES 217-Like Group no longer satisfies one or more of the eligibility criteria specified in this Rule.
- (b) TennCare Standard enrollees who are disenrolled from TennCare pursuant to this Rule shall be allowed to re-enroll in the TennCare program at any time if they become TennCare Medicaid-eligible or eligible for the CHOICES 217-Like Group, in accordance with this Rule, and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate

the enrollee's responsibility for unpaid premiums or copayments incurred under any previous period of eligibility.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Subpart (i) of Part 1. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (i) which shall read as follows::

- (i) Children under the age of twenty-one (21) years who are eligible for Supplemental Security Income.

Emergency Rule Subpart (iii) of Part 1. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

- (iii) Children under the age of twenty-one (21) years in an institutional eligibility category who are receiving care in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR), and children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation.

Emergency Rule Subpart (iv) of Part 1. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iv) which shall read as follows:

- (iv) Enrollees living in areas where there is insufficient MCO capacity to serve them.

Emergency Rule Paragraph (2) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

Emergency Rule Subparagraph (e) of Paragraph (2) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (e) which shall read as follows:

- (e) TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, spouse, child over age eighteen (18) or responsible party as defined in Rule 1200-13-14-.01.

Emergency Rule Subparagraph (a) of Paragraph (3) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (a) which shall read as follows:

- (a) When it has been determined that an individual no longer meets the criteria for TennCare eligibility, that individual shall be disenrolled from the TennCare Program. Services provided by the TennCare MCO in which the individual has been placed, as well as the PBM and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due process procedures as described elsewhere in this Chapter. Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

The introductory Emergency Rule paragraph of Subparagraph (a) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph of Subparagraph (a) which shall read as follows:

- (a) TennCare MCCs shall cover the following services and benefits subject to any applicable limitations described herein. TennCare MCCs shall cover TennCare CHOICES services and benefits in accordance with Rule 1200-13-01-.05.

The introductory Emergency Rule paragraph to Subparagraph (b) of Paragraph (1) Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph of Subparagraph (b) which shall read as follows:

- (b) The following physical health and mental health benefits are covered under the TennCare managed care program. Benefits offered under the TennCare CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.05. There are some exclusions to the benefits listed below. The exclusions are listed in this rule and in Rule 1200-13-14-.10.

Emergency Rule Part 5. Convalescent Care of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services which deleted Part 5. in its entirety and subsequent parts renumbered accordingly is replaced with Rulemaking Hearing Rule to delete Part 5.

Emergency Rule Part 9. Home Health Care of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 9. which shall read as follows:

Service	Benefit for Persons Under Age 21	Benefit for Persons Aged 21 and Older
9. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e) and at Rule 1200-13-14-.01].	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.

Emergency Rule Part 25. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 25. which shall read as follows:

Service	Benefit for Persons Under Age 21	Benefit for Persons Aged 21 and Older
25. Pharmacy Services [defined at 42 CFR §440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office, which are the responsibility of the MCO. For TennCare Standard children	Not covered; except for adults enrolled in the Standard Spend Down (SSD) category and in the CHOICES 217-Like Group. Adults enrolled in the Standard Spend Down (SSD) category have the same pharmacy benefits as adults in TennCare Medicaid, i.e., pharmacy services are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional

<p>facility) resident].</p>	<p>under age 21 who are Medicare beneficiaries, TennCare pays for medically necessary outpatient prescription drugs when they are covered by TennCare but not by Medicare Part D. Pharmaceuticals supplied and administered in a doctor's office to persons under age 21 are the responsibility of the MCO if not covered by Medicare.</p>	<p>drugs for these enrollees shall not be covered. Persons dually eligible for TennCare Standard and Medicare will receive their pharmacy services through Medicare Part D.</p> <p>Adults enrolled in the CHOICES 217-Like Group have the same pharmacy benefits as adults receiving TennCare-reimbursed services in a Nursing Facility as described in Rule 1200-13-13-.04, with no quantity limit on the number of prescriptions per month.</p> <p>Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply.</p> <p>The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Assistance Service Center. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.tn.gov/tenncare on the date of service shall be considered exempt from applicable prescription limits.</p> <p>The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain and make available to physicians, providers, pharmacists and the public, a list that shall indicate the drugs or types of drugs the State has determined to include. Drugs on the Prescriber Attestation List</p>
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		<p>may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation, or (ii) the requested drug is not on the Prescriber Attestation List.</p> <p>Pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless: (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service; or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit.</p> <p>Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women.</p> <p>Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in the doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare.</p>
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		Certain drugs known as DESI, LTE or IRS drugs are excluded from coverage.
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Emergency Rule Part 40. Sitter Services renumbered as part 39. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services which deleted "Sitter Services" in its entirety is replaced with Rulemaking Hearing Rule renumbered Part 39. which deletes "Sitter Services" in its entirety.

Emergency Rule Subparagraph (a) of Paragraph (2) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (a) which shall read as follows:

- (a) MCCs shall be allowed, but are not required, to use cost effective alternative services if and only if:
 1. These services are listed in the MCC contract and/or in Policy BEN 08-001; or
 2. These services are provided under the CHOICES program in accordance with Rule 1200-13-01-.05; and
 3. They are medically appropriate and cost effective.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Subpart (iii) of Part 2. of Subparagraph (f) of Paragraph (4) of Rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

- (iii) Individuals who are receiving services in the CHOICES program, an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded), or a Home and Community Based Services waiver.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule 1200-13-14-.06 Managed Care Organizations is deleted in its entirety and replaced with Rulemaking Hearing Rule 1200-13-14-.06 which shall read as follows:

Managed Care Organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical, behavioral, and long-term care services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. MCOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration as applicable. Managed Care Organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Paragraph (1) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (1) which shall read as follows:

- (1) Payment in full.
 - (a) All Participating Providers, as defined in this Chapter, must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.
 - (b) Any Non-Participating Providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees,

the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

- (c) Any Non-Participating Provider, as defined in this Chapter, who provides TennCare Program covered non-emergency services to TennCare enrollees without authorization from the enrollee's MCC does so at his own risk. He may not bill the patient for such services except as provided for in Rule 1200-13-14-.08(5).
- (d) Any Out-of-State Emergency Provider, as defined in this Chapter, who provides covered emergency services to TennCare enrollees in accordance with this Chapter must accept as payment in full the amounts paid by the MCC plus any copayment required by the TennCare Program.

Emergency Rule Paragraph (2) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (2) which shall read as follows:

(2) Non-Participating Providers.

- (a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in this Chapter, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.
- (b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. Emergency care to enrollees shall not require preauthorization.
- (c) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05.

Emergency Rule Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

- (b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the TDMHDD, if appropriate;

Emergency Rule Subparagraph (c) of Paragraph (3) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

Emergency Rule introductory paragraph to Paragraph (5) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph to Paragraph (5) which shall read as follows:

- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in this Chapter, including those who are Out-of-Network Providers in a particular enrollee's MCC. These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service.

Emergency Rule Subparagraph (c) of Paragraph (6) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) The provider accepted TennCare assignment on a claim and it is determined that another payer paid an amount equal to or greater than the TennCare allowable amount.

Emergency Rule Subparagraph (i) of Paragraph (6) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (i) which shall read as follows:

- (i) The provider is a TennCare provider, as defined in this Chapter, but is not participating with a particular enrollee's MCC and is seeking to bill the enrollee as though the provider were a Non-TennCare Provider, as defined in this Chapter.

Emergency Rule Paragraph (12) of 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (12) which shall read as follows:

(12) All claims must be filed in accordance with the following:

- (a) Claims filed with an MCC must be submitted in accordance with the requirements and timeframes set forth in the MCC's contract.
- (b) All other fee-for-service claims for services delivered outside of the TennCare managed care program must be filed with the Bureau of TennCare as follows:
 - 1. All claims must be filed within one (1) year of the date of service except in the following circumstances:
 - (i) Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one (1) year after final determination of eligibility.
 - (ii) If a claim filed with Medicare on a timely basis does not automatically cross over from the Medicare carrier to the Bureau, a TennCare claim may be filed within six (6) months of notification of payment or denial from Medicare.
 - 2. Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the date the original claim was filed. The Bureau will not process submissions received after the six (6) month time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party resource.
 - 3. Should a correction document involving a suspended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Bureau within ninety (90) days from the date on the document.
 - 4. If claim is not filed within the above timeframes, no reimbursement may be made.
 - 5. Claims will be paid on a first claim approved - first claim paid basis.
 - 6. The Bureau will not reimburse providers for services for which there is no Federal Financial Participation.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

The introductory Emergency Rule paragraph of Paragraph (3) of Rule 1200-13-14-.10 Exclusions is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph of Paragraph (3) which shall read as follows:

- (3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115 waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES program or outside TennCare under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 5/13/10 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 03/03/2010

Rulemaking Hearing(s) Conducted on: (add more dates). 04/28/2010

Date: 5/13/2010

Signature: [Signature]

Name of Officer: Darin J. Gordon

Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 5/13/2010

Notary Public Signature: [Signature]

My commission expires on: 9/3/2012

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Signature]

Robert E. Cooper, Jr.
Attorney General and Reporter

5-29-10

Date

Department of State Use Only

Filed with the Department of State on: 5/27/10

Effective on: 8/25/10

[Signature]

Tre Hargett
Secretary of State

RECEIVED
2010 MAY 27 AM 11:59
SECRETARY OF STATE
PUBLICATIONS

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. §4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no public comments on these rules.

Regulatory Flexibility Addendum

Pursuant to T.C.A. § 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The types of small business that may be affected by the implementation of the CHOICES program include contracted Nursing Facilities and Home and Community Based Services Providers. Currently, there are just over 300 contracted Nursing Facility Providers. Under the existing 1915(c) HCBS Waiver Program, there are some 360 contracted HCBS providers, although there are other qualified providers who may elect to contract with MCOs for the delivery of these services under CHOICES.

The impact of these rules and the TennCare CHOICES in Long-Term Care program will be to expand certain types of Community Based Residential Alternatives to Nursing Home Care, and to increase the number of persons able to receive cost-effective care at home or in their communities.

We do not anticipate that large numbers of persons will transition out of Nursing Facilities. However, we anticipate that over time a greater percentage of persons will choose to receive HCBS, delaying or preventing placement in nursing facilities. At the same time, however, the population is aging, and more and more people will require long-term care services. Thus, while greater percentages of eligible participants may elect to receive HCBS, the net number of people receiving Nursing Facility services may not necessarily decline, depending on the overall system demands.

The response of consumers to these changes is overwhelmingly positive, as the new program will offer more options and choices with respect to long-term care services and settings, specifically allowing more people the opportunity to receive cost-effective care at home.

Reporting and administrative costs are primarily the responsibility of TennCare and our Managed Care Organizations, except for nursing facility requirements pertaining primarily to reporting instances of suspected abuse, neglect or financial exploitation to the appropriate state agency (as required pursuant to State law) and to the MCOs, and requirements pertaining to management and reporting of Critical Incidents, which apply only to HCBS providers and which are currently required under the State's existing 1915(c) waiver program. We anticipate that any costs for small businesses associated with these reporting requirements are minimal, and are nonetheless critical to ensuring the health, safety and welfare of long-term care members.

For several years, the State has attempted to increase access to HCBS through expansion of the State's existing 1915(c) waiver program. Progress has been incremental, and is subject to the availability of new funds. Moreover, continuing to deliver services to the long-term care population through a patchwork of programs and entities is confusing for persons who need the services and their families, results in less effective coordination of care, and misaligns financial incentives. Integrating long-term care services into the existing managed care system is the only way to reduce the fragmentation in the existing long-term care system, improve coordination of services, and appropriately align financial incentives in order to promote the delivery of cost-effective HCBS and the rebalancing of long-term care expenditures.

While there are a number of other managed long-term care programs in the country, none are exactly like the CHOICES program. Thus, there is no comparison to federal or state counterparts.

The program has been carefully designed to help minimize disruption in the long-term care system, ensure cost-effective delivery of services, and expand access to HCBS. Exemptions from any of the requirements specified in these rules may inadvertently impede the intended objectives of the program, undermine federal requirements, and result in increased expenditures for the State.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to TCA 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules are being promulgated so that the TennCare Standard rules do not conflict with the TennCare CHOICES program.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rules are lawfully promulgated and adopted by the Department of Finance and Administration in accordance with Tennessee Code Annotated §§ 4-5-202, 71-5-105 and 71-5-109.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The governmental entity most directly affected by these rules is the Tennessee Department of Finance and Administration.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The rules were approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these rules is not anticipated to have an effect on state and local government revenues and expenditures.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Darin J. Gordon
Director, Bureau of TennCare

- (G)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Darin J. Gordon
Director, Bureau of TennCare

- (H)** Office address and telephone number of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6443
Darin.J.Gordon@tn.gov

(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

GW10210113

Department of State
Division of Publications

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Sequence Number: **REDLINE**
Rule ID(s): _____
File Date: _____
Effective Date: _____

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
Address:	Bureau of TennCare 310 Great Circle Road Nashville, Tennessee
Zip:	37243
Phone:	(615) 507-6446
Email:	George.woods@tn.gov

Revision Type (check all that apply):

- ☒ Amendments
☐ New
☐ Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables. Please enter only **ONE Rule Number/RuleTitle per row)**

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	Rule Title
1200-13-14-.01	Definitions
1200-13-14-.02	Eligibility
1200-13-14-.03	Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCs)
1200-13-14-.04	Covered Services
1200-13-14-.05	Enrollee Cost Sharing
1200-13-14-.06	Managed Care Organizations
1200-13-14-.08	Providers
1200-13-14-.10	Exclusions

Chapter 1200-13-14
TennCare Standard

Emergency Rule Paragraph (6) Benefits of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (6) which shall read as follows:

- (6) Benefits shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees. Additional benefits are available through the TennCare CHOICES program, as described in ~~the Bureau's rules at Rule 1200-13-01-.05.~~ CHOICES benefits are available only to persons who qualify for and are enrolled in the CHOICES program.

Emergency Rule Paragraphs (13), (14), (15), and (16) of Rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraphs (13), (14), (15), and (16) which shall read as follows:

- (13) CHOICES. See "TennCare CHOICES in Long-Term Care."
(14) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.
(15) CHOICES Group 1. See definition in Rule 1200-13-01-.02.
(16) CHOICES Group 2. See definition in Rule 1200-13-01-.02.

Emergency Rule Paragraph (25) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a Rulemaking Hearing Rule Paragraph (25) which shall read as follows:

- (25) Contract Provider shall have the same meaning as Participating Provider.

Emergency Rule Paragraph (30) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (30) which shall read as follows:

- (30) 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 copayments.

Emergency Rule Paragraph (31) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (31) which shall read as follows:

- (31) Covered Services shall mean the services and benefits that:
- (a) TennCare contracted MCCs cover, as set out elsewhere in ~~these rules~~ this Chapter and in Rule 1200-13-01-.05; or
 - (b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1915(c) of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

Emergency Rule Paragraph (62) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (62) which shall read as follows:

- (62) In-Network Provider shall have the same meaning as Participating Provider.

Emergency Rule Paragraph (68) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (68) which shall read as follows:

- (68) Long-Term Care shall mean programs and services described under Rule 1200-13-01-.01.

Emergency Rule Paragraph (70) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (70) which shall read as follows:

- (70) MCO (Managed Care Organization) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program.

Emergency Rule Paragraphs (82), (83), and (84) of Rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraphs (82), (83), and (84) which shall read as follows:

- (82) Non-Contract Provider shall have the same meaning as Non-Participating Provider.
- (83) Non-Participating Provider shall mean a TennCare provider, as defined in ~~these rules~~ this Rule, who is not contracted with a particular enrollee's MCO. This term may include TennCare providers who furnish services outside the managed care program on a fee-for-service basis, as well as TennCare providers who receive Medicare crossover payments from TennCare.
- (84) Non-TennCare Provider shall mean a provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

Emergency Rule Paragraphs (87) and (88) of Rule 1200-13-14-.01 Definitions are deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraphs (87) and (88) which shall read as follows:

- (87) Out-of-Network Provider shall have the same meaning as Non-Participating Provider.
- (88) Out-of-State Emergency Provider shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in ~~these rules~~ this Chapter, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he must abide by all TennCare rules and regulations, including ~~the rules about those concerning~~ provider billing of enrollees as found in Rule 1200-13-14-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, and they must not be excluded from participation in Medicare or Medicaid.

Emergency Rule Paragraph (90) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (90) which shall read as follows:

- (90) Participating Provider shall mean a TennCare provider, as defined in ~~these rules~~ this Rule, who has entered into a contract with an enrollee's Managed Care Contractor.

Emergency Rule Paragraph (100) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (100) which shall read as follows:

- (100) Provider shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:
 - (a) Participating Providers or In-Network Providers
 - (b) Non-Participating Providers or Out-of-Network Providers
 - (c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in ~~these rules~~ this Rule.

Emergency Rule Paragraph (124) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (124) which shall read as follows:

(124) TennCare CHOICES in Long-Term Care shall mean the program described in Rule 1200-13-01-.05.

Emergency Rule Paragraph (128) of Rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (128) which shall read as follows:

- (128) TennCare Provider shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in ~~these rules~~ this Rule, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including ~~the rules~~ requirements regarding provider billing of patients as found in Rule 1200-13-14-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

- (b) The Bureau of TennCare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the TennCare Program. The Bureau is responsible for establishing policy and procedural requirements and criteria for TennCare.
1. With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.
 2. With respect to the eligibility of individuals applying for the TennCare CHOICES program, the Bureau is responsible for determining that the individual meets level of care eligibility criteria for the long-term care services or reimbursement requested. For enrollment into CHOICES Group 2, the Bureau is also responsible for determining the state's ability to provide appropriate Home and Community Based Services (HCBS) as determined by the availability of slots under the established enrollment target in accordance with Rule 1200-13-01-.05 and for confirming a determination by an Area Agency on Aging and Disability or TennCare Managed Care Organization that:
 - (i) The individual is an adult aged sixty-five (65) or older, or an adult aged twenty-one (21) or older with physical disabilities; and
 - (ii) Such individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's cost neutrality cap pursuant to Rule 1200-13-01-.05.
 3. The Bureau is responsible for granting, at its discretion, immediate eligibility for persons applying for enrollment into CHOICES Group 2, pursuant to Rule 1200-13-01-.05.

Emergency Rule Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

- (b) Provide a statement from his employer, if employed, concerning the availability of group health insurance. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Emergency Rule Subparagraph (g) of Paragraph (3) of Rule 1200-13-14-.02 Eligibility which added the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph is replaced with Rulemaking Hearing Rule Subparagraph (g) which shall read as follows:

- (g) Not be eligible for or have purchased other health insurance as defined at Rule 1200-13-14-.01, except for persons in the category of uninsured children under the age of nineteen (19) whose family income is below two hundred percent (200%) of poverty and who have been continuously enrolled in

TennCare Standard since at least December 31, 2001. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Emergency Rule Subparagraph (h) of Paragraph (3) of Rule 1200-13-14-.02 Eligibility which added the phrase "or the CHOICES 217-Like Group" at the end of the Subparagraph is replaced by Rulemaking Hearing Subparagraph (h) which shall read as follows:

- (h) Not be enrolled in, or eligible for participation in, Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Emergency Rule Paragraph (7) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (7) which shall read as follows:

(7) TennCare Standard: CHOICES 217-Like Group

- (a) Coverage 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 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 Nursing Facility (NF) care. This group exists only in the Grand Divisions of the state where the CHOICES program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

(b) Eligibility criteria:

1. Must be aged sixty-five (65) and older or aged twenty-one (21) and older with physical disabilities as defined in Rule 1200-13-01-.02;
2. Must meet the Nursing Facility level of care requirements;
3. Must have a current determination by an Area Agency on Aging and Disability or the TennCare MCO to which the individual is assigned, that he is able to be safely and appropriately served in the community and within his individual cost neutrality cap as defined in Rule 1200-13-01-.05;
4. May be enrolled in accordance with requirements pertaining to the enrollment target for CHOICES Group 2, as described in Rule 1200-13-01-.05;
5. Will be enrolled and begin receiving Home and Community Based Services (HCBS) upon determination of financial eligibility by DHS and continue to receive HCBS as a CHOICES Group 2 participant. Qualifying for enrollment into CHOICES Group 2 (HCBS) is not sufficient to establish eligibility in the CHOICES 217-Like Group if the person will not actually be enrolled and receiving HCBS; and
6. Would be eligible in the same manner as specified under 42 C.F.R. § 435.217, 435.236, and 435.726 and section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-d), if the Home and Community Based Services (HCBS) were provided under a section 1915(c) waiver.

(c) Application procedures

1. To be eligible for the CHOICES 217-Like Group, each individual must meet all technical and financial requirements applicable to this category as described in DHS Rule Chapter 1240-03-03.
2. The effective date of eligibility in the CHOICES 217-Like Group shall be the date of approval the application is approved by DHS; unless TennCare has granted Immediate Eligibility pursuant to Rule 1200-13-01-.05(3)(f), in which case, the effective date of eligibility in the CHOICES 217-Like HCBS Group shall be the effective date of Immediate Eligibility granted by TennCare. In no instance shall the effective date of eligibility precede the date the application was filed with DHS.

The Emergency Rule introductory sentence to paragraph (8) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory sentence which shall read as follows:

(8) Redetermination of eligibility in TennCare Standard (other than CHOICES 217-Like Group).

Emergency Rule Subparagraph (c) of Paragraph (8) of Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) Information to be recertified includes changes in address, income, employment, family size, and access to health insurance (access to insurance is not considered in determining eligibility in the Standard Spend Down category). Redetermination appointments must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice reminding the enrollee that he must have his eligibility redetermined will inform the enrollee of the documentation to be brought to the appointment.

Emergency Rule renumbered Paragraph (9) of 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (9) which shall read as follows:

(9) Redetermination of eligibility in the CHOICES 217-Like Group.

An enrollee who qualifies for TennCare through DHS shall have his TennCare eligibility redetermined by DHS as required by the appropriate category of medical assistance, ~~as described in Chapter 1240-03-03 of the rules of DHS — Division of Medical Services.~~ Prior to termination, eligibility will be reviewed in accordance with the following process:

- (a) At least thirty (30) days prior to the expiration of his current eligibility period, the Bureau of TennCare will send a Request for Information to the enrollee. The Request for Information will include a form to be completed with information needed to verify continued eligibility in the CHOICES 217-Like Group.
- (b) 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 DHS and to provide DHS with the necessary verifications to determine continued eligibility for the CHOICES 217-Like Group.
- (c) Enrollees with a health problem, mental health problem, 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.
- (d) If an enrollee provides some but not all of the necessary information to DHS to verify his continued eligibility for the CHOICES 217-Like Group during the thirty (30) day period following the Request for Information, DHS 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.
- (e) Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare (subject to any changes in covered services generally applicable to enrollees in their eligibility category) while DHS reviews their eligibility in the CHOICES 217-Like Group.
- (f) Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare while DHS reviews their eligibility in the CHOICES 217-Like Group. If DHS determines that the enrollee remains eligible for his current CHOICES 217-Like category, the enrollee will remain enrolled in such category. If DHS makes a determination that the enrollee is not eligible for continued enrollment in the CHOICES 217-Like Group, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.
- (g) Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage.

Renumbered Emergency Rules Subparagraphs (a), (b), (c), (d), (m), (n), (o) and Unnumbered Paragraph of Paragraph (10) of Rule 1200-13-14-.02 Eligibility is deleted in their entirety and replaced with Rulemaking Hearing Rule Paragraph (10) which shall read as follows:

(10) Losing eligibility for TennCare Standard.

- (a) Eligibility for TennCare Standard shall cease when it has been determined that the enrollee, as the result of one of the following events, no longer meets the criteria for the program. Eligibility for TennCare Standard shall end if:
 - 1. The enrollee becomes eligible for participation in a group health insurance plan, as defined in this Chapter, either directly or indirectly through a family member. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);
 - 2. The enrollee becomes eligible for Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);
 - 3. The enrollee is determined eligible for Medicaid (this does not apply to the CHOICES 217-Like Group, unless the enrollee begins receiving SSI);
 - 4. The enrollee purchases an individual health insurance plan as defined by this Chapter. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);
 - 5. The enrollee fails to comply with TennCare Program requirements, subject to federal and state laws and regulations;
 - 6. The enrollee dies;
 - 7. It is determined that any of the technical eligibility requirements found in this Rule are no longer met;
 - 8. The enrollee has failed to respond to a redetermination process requirement, as described in this Rule, to assure that the enrollee and other family members, as appropriate, remain eligible for TennCare Standard;
 - 9. The enrollee sends a voluntary written request for termination of eligibility for TennCare Standard to the DHS county office in the county in which he resides;
 - 10. The enrollee no longer qualifies as a resident of Tennessee under federal and state law;
 - 11. The enrollee fails to complete the redetermination process within the timeframes specified within this Rule;
 - 12. The enrollee becomes incarcerated as an inmate;
 - 13. The Bureau determines that the enrollee does not actually have the medical condition(s) which rendered him "medically eligible" for TennCare Standard;
 - 14. The enrollee attains the age of nineteen (19) and has not been determined eligible in an open Medicaid category; or
 - 15. An enrollee in the CHOICES 217-Like Group no longer satisfies one or more of the eligibility criteria specified in this Rule.
- (b) TennCare Standard enrollees who are disenrolled from TennCare pursuant to this Rule shall be allowed to re-enroll in the TennCare program at any time if they become TennCare Medicaid-eligible or eligible for the CHOICES 217-Like Group, in accordance with this Rule, and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate

the enrollee's responsibility for unpaid premiums or copayments incurred under any previous period of eligibility.

~~Subparagraph (a) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (a) shall read as follows:~~

- ~~(a) The enrollee becomes eligible for participation in a group health insurance plan, as defined in these rules, either directly or indirectly through a family member. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);~~

~~Subparagraph (b) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (b) shall read as follows:~~

- ~~— (b) The enrollee becomes eligible for Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);~~

~~Subparagraph (c) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "(this does not apply to the CHOICES 217-Like Group, unless the enrollee begins receiving SSI)" at the end of the subparagraph so as amended subparagraph (c) shall read as follows:~~

- ~~— (c) The enrollee is determined eligible for Medicaid (this does not apply to the CHOICES 217-Like Group, unless the enrollee begins receiving SSI);~~

~~Subparagraph (d) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (d) shall read as follows:~~

- ~~— (d) The enrollee purchases an individual health insurance plan as defined by these rules. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);~~

~~Subparagraph (m) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by deleting the word "or" at the end of the subparagraph so as amended subparagraph (m) shall read as follows:~~

- ~~(m) The Bureau determines that the enrollee does not actually have the medical condition(s) which rendered him "medically eligible" for TennCare Standard;~~

~~Subparagraph (n) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the punctuation and word "; or" at the end of the subparagraph so as amended subparagraph (n) shall read as follows:~~

- ~~(n) The enrollee attains the age of nineteen (19) and has not been determined eligible in an open Medicaid category; or~~

~~Paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding a new paragraph (o) which shall read as follows:~~

- ~~— (o) An enrollee in the CHOICES 217-Like Group no longer satisfies one or more of the eligibility criteria specified in these rules.~~

~~The unnumbered paragraph following new subparagraph (o) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or eligible for the CHOICES 217-Like Group, in accordance with these rules," after the words "Medicaid-eligible" in the first sentence so as amended the unnumbered paragraph shall read as follows:~~

~~TennCare Standard enrollees who are disenrolled from TennCare pursuant to these rules shall be allowed to re-enroll in the TennCare program at any time if they become TennCare Medicaid-eligible or eligible for the CHOICES 217-Like Group, in accordance with these rules, and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate the enrollee's responsibility for unpaid premiums or copayments incurred under any previous period of eligibility~~

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Subpart (i) of Part 1. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (i) which shall read as follows::

- (i) Children under the age of twenty-one (21) years who are eligible for Supplemental Security Income.

Emergency Rule Subpart (iii) of Part 1. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

- (iii) Children under the age of twenty-one (21) years in an institutional eligibility category who are receiving care in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR), and children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation.

Emergency Rule Subpart (iv) of Part 1. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iv) which shall read as follows:

- (iv) Enrollees living in areas where there is insufficient MCO capacity to serve them.

Emergency Rule Paragraph (2) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

Emergency Rule Subparagraph (e) of Paragraph (2) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (e) which shall read as follows:

- (e) TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, spouse, child over age eighteen (18) or responsible party as defined in Rule 1200-13-14-.01.

Emergency Rule Subparagraph (a) of Paragraph (3) of Rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (a) which shall read as follows:

- (a) When it has been determined that an individual no longer meets the criteria for TennCare eligibility, that individual shall be disenrolled from the TennCare Program. Services provided by the TennCare MCO in which the individual has been placed, as well as the PBM and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due

process procedures as described elsewhere in ~~these rules~~ this Chapter. Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

The introductory Emergency Rule paragraph of Subparagraph (a) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph of Subparagraph (a) which shall read as follows:

- (a) TennCare MCCs shall cover the following services and benefits subject to any applicable limitations described herein. TennCare MCCs shall cover TennCare CHOICES services and benefits in accordance with Rule 1200-13-01-.05.

The introductory Emergency Rule paragraph to Subparagraph (b) of Paragraph (1) Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph of Subparagraph (b) which shall read as follows:

- (b) The following physical health and mental health benefits are covered under the TennCare managed care program. Benefits offered under the TennCare CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.05. There are some exclusions to the benefits listed below. The exclusions are listed in this rule and in Rule 1200-13-14-.10.

Emergency Rule Part 5. Convalescent Care of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services which deleted Part 5. in its entirety and subsequent parts renumbered accordingly is replaced with Rulemaking Hearing Rule to delete Part 5.

Emergency Rule Part 9. Home Health Care of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 9. which shall read as follows:

Service	Benefit for Persons Under Age 21	Benefit for Persons Aged 21 and Older
9. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e) and at Rule 1200-13-14-.01].	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.

Emergency Rule Part 25. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 25. which shall read as follows:

Service	Benefit for Persons Under Age 21	Benefit for Persons Aged 21 and Older
25. Pharmacy Services [defined at 42 CFR §440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office,	Not covered; except for adults enrolled in the Standard Spend Down (SSD) category and in the CHOICES 217-Like Group. Adults enrolled in the Standard Spend Down (SSD) category have the same pharmacy benefits as adults in TennCare Medicaid, i.e., pharmacy services are limited to

<p>pharmacy, or those administered to a long-term care facility (nursing facility) resident].</p>	<p>which are the responsibility of the MCO.</p> <p>For TennCare Standard children under age 21 who are Medicare beneficiaries, TennCare pays for medically necessary outpatient prescription drugs when they are covered by TennCare but not by Medicare Part D. Pharmaceuticals supplied and administered in a doctor's office to persons under age 21 are the responsibility of the MCO if not covered by Medicare.</p>	<p>five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for these enrollees shall not be covered. Persons dually eligible for TennCare Standard and Medicare will receive their pharmacy services through Medicare Part D.</p> <p>Adults enrolled in the CHOICES 217-Like Group have the same pharmacy benefits as adults receiving TennCare-reimbursed services in a Nursing Facility as described in Rule 1200-13-13-.04, with no quantity limit on the number of prescriptions per month.</p> <p>Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply.</p> <p>The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Service Assistance <u>Service</u> Centers. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.state.tn.us.tn.gov/tenncare <u>www.tn.gov/tenncare</u> on the date of service shall be considered exempt from applicable prescription limits.</p> <p>The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain and make available to physicians,</p>
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		<p>providers, pharmacists and the public, a list that shall indicate the drugs or types of drugs the State has determined to include. Drugs on the Prescriber Attestation List may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation, or (ii) the requested drug is not on the Prescriber Attestation List.</p> <p>Pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless: (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service; or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit.</p> <p>Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women.</p> <p>Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in the doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for</p>
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		<p>Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare.</p> <p>Certain drugs known as DESI, LTE or IRS drugs are excluded from coverage.</p>
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Emergency Rule Part 40. Sitter Services renumbered as part 39. of Subparagraph (b) of Paragraph (1) of Rule 1200-13-14-.04 Covered Services which deleted "Sitter Services" in its entirety is replaced with Rulemaking Hearing Rule renumbered Part 39. which deletes "Sitter Services" in its entirety.

Emergency Rule Subparagraph (a) of Paragraph (2) of Rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (a) which shall read as follows:

- (a) MCCs shall be allowed, but are not required, to use cost effective alternative services if and only if:
 - 1. These services are listed in the MCC contract and/or in Policy BEN 08-001; or
 - 2. These services are provided under the CHOICES program in accordance with Rule 1200-13-01-.05; and
 - 3. They are medically appropriate and cost effective.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Subpart (iii) of Part 2. of Subparagraph (f) of Paragraph (4) of Rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

- (iii) Individuals who are receiving services in the CHOICES program, an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded), or a Home and Community Based Services waiver.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule 1200-13-14-.06 Managed Care Organizations is deleted in its entirety and replaced with Rulemaking Hearing Rule 1200-13-14-.06 which shall read as follows:

Managed Care Organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical, behavioral, and long-term care services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. MCOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration as applicable. Managed Care Organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule Paragraph (1) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (1) which shall read as follows:

- (1) Payment in full.

- (a) All Participating Providers, as defined in ~~these rules~~ this Chapter, must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.
- (b) Any Non-Participating Providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.
- (c) Any Non-Participating Provider, as defined in ~~these rules~~ this Chapter, who provides TennCare Program covered non-emergency services to TennCare enrollees without authorization from the enrollee's MCC does so at his own risk. He may not bill the patient for such services except as provided for in Rule 1200-13-14-.08(5).
- (d) Any Out-of-State Emergency Provider, as defined in ~~these rules~~ this Chapter, who provides covered emergency services to TennCare enrollees in accordance with ~~these rules~~ this Chapter must accept as payment in full the amounts paid by the MCC plus any copayment required by the TennCare Program.

Emergency Rule Paragraph (2) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (2) which shall read as follows:

(2) Non-Participating Providers.

- (a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in ~~these rules~~ this Chapter, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.
- (b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. Emergency care to enrollees shall not require preauthorization.
- (c) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05.

Emergency Rule Subparagraph (b) of Paragraph (3) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

- (b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the TDMHDD, if appropriate;

Emergency Rule Subparagraph (c) of Paragraph (3) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

Emergency Rule introductory paragraph to Paragraph (5) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph to Paragraph (5) which shall read as follows:

- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in ~~these rules~~ this Chapter, including those who are Out-of-Network Providers in a particular enrollee's MCC. These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service.

Emergency Rule Subparagraph (c) of Paragraph (6) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

- (c) The provider accepted TennCare assignment on a claim and it is determined that another payer paid an amount equal to or greater than the TennCare allowable amount.

Emergency Rule Subparagraph (i) of Paragraph (6) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (i) which shall read as follows:

- (i) The provider is a TennCare provider, as defined in ~~these rules~~ this Chapter, but is not participating with a particular enrollee's MCC and is seeking to bill the enrollee as though the provider were a Non-TennCare Provider, as defined in ~~these rules~~ this Chapter.

Emergency Rule Paragraph (12) of Rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (12) which shall read as follows:

(12) All claims must be filed in accordance with the following:

- (a) Claims filed with an MCC must be submitted in accordance with the requirements and timeframes set forth in the MCC's contract.
- (b) All other fee-for-service claims for services delivered outside of the TennCare managed care program must be filed with the Bureau of TennCare as follows:
 - 1. All claims must be filed within one (1) year of the date of service except in the following circumstances:
 - (i) Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one (1) year after final determination of eligibility.
 - (ii) If a claim filed with Medicare on a timely basis does not automatically cross over from the Medicare carrier to the Bureau, a TennCare claim may be filed within six (6) months of notification of payment or denial from Medicare.
 - 2. Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the date the original claim was filed. The Bureau will not process submissions received after the six (6) month time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party resource.
 - 3. Should a correction document involving a suspended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Bureau within ninety (90) days from the date on the document.
 - 4. If claim is not filed within the above timeframes, no reimbursement may be made.
 - 5. Claims will be paid on a first claim approved - first claim paid basis.
 - 6. The Bureau will not reimburse providers for services for which there is no Federal Financial Participation.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

The introductory Emergency Rule paragraph of Paragraph (3) of Rule 1200-13-14-.10 Exclusions is deleted in its entirety and replaced with Rulemaking Hearing Rule introductory paragraph of Paragraph (3) which shall read as follows:

- (3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115(a) waiver program unless excepted by paragraph (2) herein. Some of

these services may be covered under the CHOICES program or outside TennCare under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.