RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-03-02
COVERAGE GROUPS UNDER MEDICAID

TABLE OF CONTENTS

1240-03-02-.01 Necessity and Function
1240-03-02-.02 Coverage of the Categorically Needy
1240-03-02-.03 Coverage of the Medically Needy
1240-03-02-.04 Enrollment for Standard Spend Down Individuals

1240-03-02-.01 NECESSITY AND FUNCTION. The Department of Human Services has responsibility to determine eligibility for medical assistance in accordance with Title XIX of the Social Security Act. T.C.A. §§ 71-5-102, 71-5-104 and 71-5-106 empower the Department to comply with any requirement that may be imposed or opportunity presented by Federal law for the provision of medical assistance in Tennessee. Federal regulations set forth the mandatory and optional groups of the Medicaid Program [42 C.F.R. §§ 435.100, 435.200 and 435.300].

Authority: *T.C.A. §§4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-104, 71-5-106, 71-5-109 and 71-5-111; 42 U.S.C. §§ 1396 et seq.; and 42 C.F.R. §§ 435.100, 435.200 and 435.300.* ***Administrative History:*** *Original rule filed June 14, 1976; effective July 14, 1976. Amendment filed June 9, 1981; effective October 5, 1981. Amendment filed August 17, 1982; effective September 16, 1982. Amendment filed April 22, 2008; effective July 6, 2008.*

1240-03-02-.02 COVERAGE OF THE CATEGORICALLY NEEDY. The following groups of categorically needy individuals, if otherwise eligible, are covered:

(1) Recipients Of Cash Assistance (Money Payments).

(a) All individuals receiving foster care maintenance payments or adoption assistance payments under Title IV-E of the Social Security Act are deemed eligible for Medicaid.

(b) All individuals receiving a benefit under Title XVI, Supplemental Security Income Program.

(c) All individuals receiving a State Supplemental payment.

(2) Medicaid Only (Non-Money Payment).

(a) Effective July 1, 2007, Medicaid and Families First de-linked. Eligibility for Families First will no longer mean automatic entitlement to Medicaid coverage. Families First applicants and recipients who also desire Medicaid must apply and have eligibility determined separate and apart from Families First.

1. Medicaid eligibility for Families First applicants and recipients, as well as Medicaid eligibility for those who are not applying for Families First will be considered in the AFDC-MO category. AFDC-MO provides Medicaid under Section 1931 of Title XIX of the Social Security Act [42 U.S.C. § 1396u-1] to individuals who meet the AFDC eligibility requirements in effect prior to July 16, 1996 in accordance with certain modifications approved by the Centers for Medicare and Medicaid Services (CMS) to Tennessee’s State Plan as outlined in the Attachment 2.6-A, Supplement 12, page 1 and 2 of the State Plan.

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

(i) An AFDC-MO case terminated for earnings or increased earnings will continue eligible for Medicaid Only for an additional twelve (12) calendar months beginning with the month in which the family becomes ineligible for assistance except for the caretaker who is sanctioned for failure to comply with child support services. [42 U.S.C. § 608(a)(11), 42 U.S.C. § 1315, 42 U.S.C. § 1396u-1, 42 U.S.C. § 1396r-6 and 42 U.S.C. § 1396a(e)(1)]

(ii) Effective July 1, 2007 an AFDC-MO case terminated for receipt of spousal or child support will continue eligible for Medicaid Only for an additional twelve (12) months beginning with the month the family becomes ineligible for assistance.

(b) Any person or family who would be eligible for Families First/AFDC or SSI except for a requirement which is specially prohibited under Title XIX of the Social Security Act.

(c) Any Social Security beneficiary who would be currently eligible for Families First/AFDC or SSI if the Social Security increase in September, 1972, was disregarded, provided:

1. He received Old Age Assistance (OAA), Assistance for the Blind (AB), Assistance for the Disabled (AD), or Aid For Dependent Children (AFDC) in August 1972; and

2. Was also entitled to Social Security monthly benefits for August 1972.

(d) All aged, blind or disabled individuals in skilled or intermediate care as patients in the month of December 1973, who:

1. Would have received an OAA, AB, or AD money payment had they not been in skilled or intermediate care; and

2. Were certified for Medicaid Only on the basis of need for skilled or intermediate care; and

3. Continue to be eligible for Medicaid coverage because they:

(i) Continue to be patients in skilled or intermediate care facilities;

(ii) Continue to require skilled or intermediate care; and

(iii) Continue to meet all requirements as an OAA, AB, or AD Medicaid Only care according to policy in effect in December 1973, as contained in Volume II of the Public Welfare Manual.

(e) Any aged, blind, or disabled (AABD) individual who loses eligibility for Supplemental Security Income (SSI) benefits due to a Social Security (Title II) cost of living increase beginning in July 1977, but who would be eligible for SSI if cost of living adjustments received since their SSI termination were disregarded.

(f) Any aged, blind or disabled (AABD) individual institutionalized in a medical institution (i.e., one organized to provide medical care) or in Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) of the Social Security Act [42 U.S.C. § 1396n(c)] HCBS waiver program who has income equal to or less than three hundred percent (300%) of the SSI Federal Benefit Rate and who meet all applicable technical and financial eligibility criteria.

1. TennCare CHOICES Program has two (2) components:

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

(i) Nursing Facility Services.

(ii) Home and Community Based Services (HCBS) for adults who are elderly or physically disabled.

2. There are two groups in TennCare CHOICES.

(i) CHOICES Group 1. Participation in CHOICES Group 1 is limited to Medicaid enrollees of all ages who qualify for and are receiving Medicaid-reimbursed Nursing Facility services. Medicaid eligibility for long-term care services is determined by the Department of Human Services (DHS). Medical (or level of care) eligibility is determined by TennCare as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid and qualify for Medicaid-reimbursement of long-term care services.

(ii) CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility level of care and who qualify for TennCare either as SSI recipients or in the CHOICES 217-Like group and who need and are receiving HCBS as an alternative to NF care. Eligibility for the CHOICES 217-Like Group will be determined using the technical and financial criteria of the institutional eligibility category. TennCare has the discretion to apply an enrollment target to this group.

(I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.

(II) The CHOICES 217-Like Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by the Department of Human Services. Persons who qualify in the CHOICES 217-Like Group in accordance with Rule 1200-13-14-.02 are enrolled in TennCare Standard.

(g) Individuals who would be eligible for cash assistance (Families First/AFDC or SSI) except for their institutional status.

(h) Pregnant women who meet the income and resource standards of the Families First/AFDC cash assistance program. If eligible for and receiving Medicaid on the date of delivery, eligibility automatically continues for two full calendar months, beginning with the month following the month of delivery.

(i) A newborn infant may remain eligible for medicaid for a period of up to one year on the following conditions:

1. The mother was eligible for medicaid at the time the infant was born;

2. The mother would be eligible for medicaid if she were still pregnant; and

3. The child remains in the same household as the mother.

(j) Caretakers and their deprived children to age 21 when income from a sibling(s) (including half or step sibling) causes ineligibility for money payment.

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

(k) Pregnant women and infants up to one (1) year old who meet the income standards based on one hundred eighty-five percent (185%) of the federal poverty guidelines for the family size. If an application is made no later than delivery date and the pregnant woman is eligible at any time during the application processing period, eligibility continues without regard to income changes throughout the pregnancy. Eligibility continues for the pregnant woman two (2) full calendar months after the month pregnancy ends regardless of changes in the pregnant woman's eligibility status. A woman eligible under this subparagraph will receive full coverage in addition to pregnancy-related services. For purposes of this subparagraph, "pregnancy-related services" may mean any service eligible for coverage under the Medicaid program that potentially affects the pregnancy.

(l) Children age six or older who were born on or after October 1, 1983, whose family income does not exceed 100% of the Federal poverty guidelines and who meet all eligibility requirements.

(m) Any aged, blind, or disabled individual who loses eligibility for Supplemental Security Income (SSI) benefits due to any increase in income other than a Social Security (Title II) cost-of-living increase beginning in July 1977, but who would be eligible for SSI if cost of living adjustments received since their SSI termination were disregarded. (Commonly known as the Pickle Amendment.)

(n) Effective January 1, 1998, individuals who meet eligibility requirements for Specified Low-Income Beneficiaries (SLIB) except that income is greater than one hundred twenty percent (120%) of federal poverty guidelines, but not greater than one hundred thirty-five percent (135%) may be eligible for state buy-in of Part B Medicare premiums, if not currently eligible for or receiving Medicaid or TennCare on "first come, first served" basis up to the State's allocation of federal funds. This group is referred to as Qualifying Individuals 1 (QI1).

(o) Individuals under age 21 (or to age 22 if completing a course of treatment begun prior to the 21st birthday) receiving inpatient psychiatric care in a facility accredited by the Joint Commission for Accreditation of Hospitals.

(p) Legal aliens; immigrants who are not age sixty-five (65) or older, blind, disabled, or under age eighteen (18); undocumented aliens; and other aliens who do not have permanent resident status, including illegal aliens as specified under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and the Deficit Reduction Act of 2005 (DRA), if otherwise eligible, may qualify for emergency medical services where the individual has a medical condition, including emergency labor and delivery, manifested by acute symptoms of sufficient severity which, if not attended to immediately, could reasonably be expected to result in placing the patient's health in serious jeopardy, severe impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(q) Pregnant women who meet the applicable income levels for the categorically needy (i.e., those whose total income does not exceed one hundred eighty-five percent (185%) of the Federal poverty guidelines and who are determined eligible by a qualified provider for a presumptive eligibility period in accordance with Section 1920 of the Social Security Act) are eligible for ambulatory prenatal services. Only one (1) presumptive period of eligibility is allowed for each pregnancy.

(r) Qualified Medicare Beneficiaries who are entitled to Medicare Part A may be eligible for a State buy-in of their Medicare premiums, coinsurance and deductibles, if their resources do not exceed two hundred percent (200%) of the SSI resource limit for an individual or couple, as provided at 42 USC § 1382b and whose incomes do not

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

exceed one hundred percent (100%) of the current federal poverty guidelines.

(s) Qualified Disabled and Working Individuals who have not attained the age of 65, who would not otherwise be eligible for Medicare, who continue to meet the Social Security Administration's definition of disability or blindness (Title II), and whose entitlement to disability benefits ended solely because such individual's earnings exceeded the substantial gainful activity amount are eligible for a state buy-in of their Medicare Part A premiums, effective July 1, 1990 forward, provided such individual's income does not exceed 200% of the federal poverty guidelines applicable to a family of the size involved, provided such individual's resources do not exceed twice the maximum amount of resources that an individual or a couple may have under the SSI program and provided that the individual is not otherwise eligible for Medicaid.

(t) Children born on or after October 1, 1983, who have obtained the age of one year old but who have not obtained the age of six years old where family income does not exceed 133% of the Federal poverty guidelines and who meet all eligibility requirements.

(u) Specified Low-Income Medicare Beneficiaries (SLMB) who meet all of the requirements for Qualified Medicare Beneficiaries (QMB) but whose incomes are greater than one hundred percent (100%) but not greater than one hundred twenty percent (120%) of the current federal poverty guidelines may be eligible for state payment of their Part B (medical insurance) Medicare premiums if not Medicaid eligible.

(v) Disabled Widows and Widowers.

1. Any disabled widows or widowers who are between the ages of 50 and 59 and were entitled to Title II widow and widowers Social Security Benefits during December 1983 and lost their Supplemental Security Income (SSI) benefits under Title XVI as a result of elimination of the actuarial reduction factor in January 1984 but who would have continued SSI eligibility if the Social Security increase, which arose from the elimination of the actuarial reduction factor and all subsequent Cost of Living Adjustments (COLA), is disregarded provided that application for this benefit was made no later than July 1, 1987.

2. Any disabled widow or widower who lost eligibility for SSI benefits because of receiving at age 60 a spouse's retirement benefit under Title II may remain eligible for Medicaid on the following conditions:

(i) They are not entitled to Medicare Part A coverage; and

(ii) They would be eligible for SSI if cost of living adjustments and the spouse's retirement benefits were disregarded.

3. Any disabled widow(er) or disabled divorced surviving spouse who lost SSI eligibility due to a receipt of Title II benefits which were received pursuant to 1990 changes in disability criteria of 42 USC §423 may remain eligible for Medicaid on the following conditions:

(i) They are not entitled to Medicare Part A coverage; and

(ii) They would continue to be eligible for SSI if the Title II benefit was not counted as income.

(w) Disabled adult children who lose SSI eligibility after July 1, 1987 because of the receipt

of or an increase in benefits for Disabled Adult Children under Title II will remain eligible for Medicaid if the initial entitlement under Title II above and/or cost of living increase, whichever caused the ineligibility for SSI, were disregarded.

(x) Women who have been found to have breast or cervical cancer including a precancerous condition, through the National Breast and Cervical Cancer Early Detection Program, who are under age sixty-five (65) and are uninsured and not otherwise eligible for Medicaid or receiving TennCare Standard are eligible to receive Medicaid in the Breast and Cervical Cancer category.

(3) Children Under 21 In Special Living Arrangements.

(a) Children in foster care or a subsidized adoptive home;

(b) Children under the supervision of the Department, or approved public child care agency (if the Department is providing some portion of the child's cost of care), or a licensed private, non-profit child-care or child planning agency; and

(c) Who are in need according to the Families First/AFDC-FC Income and Resource Standards.

Authority *T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-3-158(d)(2)(D), 71-5-101, 71-5-102, 71-5-106, 71-5-109, 71-5-111 and 71-5-1401 et seq.; Acts 2007, Chapter 31 § 11 and Acts 2008, Chapter 1190; 8 U.S.C. §§ 1611, 1612, 1613 and 1641, 42 U.S.C. § 423 note, 42 U.S.C. § 608(a)(2), 42 U.S.C. § 608(a)(6), 42 U.S.C. § 608(a)(11), 42 U.S.C.§ 672(h), 42 U.S.C. § 673(b), 42 U.S.C. § 1315, 42 U.S.C. §§ 1382 et seq., 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(i), 42 U.S.C. § 1396a(a)10(A)(i)(1V), 42 U.S.C. § 1396a(a)(10)(E); 42 U.S.C. § 1396a(e)(1)(A), 42 U.S.C. § 1396a(e)(4)(5) and (6), 42 U.S.C. 1396a(l)(1)(D), 42 U.S.C. § 1396a(aa), 42 U.S.C. 1396b(v)(1), 42 U.S.C. § 1396d(p)(1),(2) and (3), 42 U.S.C. § 1396d(s), 42 U.S.C. § 1396n(c), 42 U.S.C. § 1396r, 42 U.S.C. § 1396r-6, 42 U.S.C.§ 1396u-1; 20 C.F.R. 416.1205(c); 42 C.F.R. §§ 435.4, 435.100, 42 C.F.R. 435.200, and 42 C.F.R. 435.831; PL 94-566 §503; PL 98-21 §134; PL 99-509 §9401; PL 100-203 §9116; PL 101-508 §5103(e), PL 104-193 §§103 and 431 and PL 109-171 § 6036 and 7101; and 71 FR 39214 (July 6, 2006).* ***Administrative History:*** *Original rule filed June 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed June 9, 1981; effective October 5, 1981. Amendment filed November 30, 1981; effective January 14, 1982. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed October 14, 1983; effective November 14, 1983. Amendment filed January 7, 1985; effective February 6, 1985. Amendment filed May 23, 1986; effective August 12, 1986. Amendment filed August 9, 1989; effective September 13, 1989. Amendment filed January 31, 1990; effective March 17, 1990. Amendment filed May 1, 1991; effective June 15, 1991. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed April 23, 1997; effective July 7, 1997. Amendment filed October 26, 2001; effective January 9, 2002 Public Necessity rule filed June 1, 2007; expires November 13, 2007. Public necessity rule filed July 2, 2007; effective through December 14, 2007. Amendment filed August 30, 2007; effective November 13, 2007. Amendments filed September 25, 2007; effective December 9, 2007. Amendment filed April 22, 2008; effective July 6, 2008. Amendments filed August 5, 2009; effective November 3, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010.*

1240-03-02-.03 COVERAGE OF THE MEDICALLY NEEDY. The following groups of medically needy individuals, if otherwise eligible, are covered:

(1) Pregnant women in one or two-parent families who, but for income and resources, would be eligible as Categorically Needy (Families First/AFDC) and who meet the Medically Needy financial requirements shall remain eligible without regard to income changes and for two (2) full calendar months of postpartum coverage regardless of changes in circumstances.

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

(2) Aged, blind and disabled non-pregnant individuals age twenty-one (21) and older are no longer eligible for coverage as Medically Needy. Effective April 30, 2005 enrollment in the Medically Needy Category was closed to new enrollees except for children under age twenty-one (21) and pregnant women. Currently eligible Medically Needy Adults will be given the opportunity to apply for Standard Spend Down. Individuals who are subsequently approved will be given coverage for a period of twelve (12) months from their begin date.

(a) Prior to actual enrollment in Standard Spend Down, the Transition Group enrollees were looked at for eligibility in an open category of Medicaid through the ex parte review process. Transition Group enrollees not found eligible in an open category of Medicaid, will be selected for Standard Spend Down processing through the Request for Information (RFI) process.

(3) Children under age twenty-one (21), Caretaker.

(a) All children under age twenty-one (21) who meet the Medically Needy technical and financial eligibility requirements. The caretaker of such children is also covered if:

1. The caretaker is pregnant; or

2. The caretaker is under age twenty-one (21).

(b) Both parents of a dependent child, if both parents are under age twenty-one (21) may be covered, if otherwise eligible.

(c) Newborns of women in one or two-parent families are covered effective from date of birth and continue as long as the child is living with the mother and the mother is Medicaid eligible or if she would be Medicaid eligible, if she were pregnant, up to one (1) year.

(4) Pregnant women and children under twenty-one (21) are classified as Exceptional Medically Needy or Spenddown Medically Needy. Persons are exceptional Medically Needy if eligibility is due to their regular monthly income being equal to or below the medically needy eligibility standards.

(5) Whenever a pregnant woman or child under twenty-one (21) has income which prevents their qualifying as Exceptional Medically Needy eligibility on the basis of income, spenddown eligibility is determined pursuant to these rules.

(6) Individuals who meet Standard Spend Down (SSD) criteria:

(a) Tennessee residents who have been determined to be eligible for the Standard Spend Down (SSD) program.

(b) Individuals enrolled must meet the following criteria:

1. Must be aged twenty-one (21) or older;

2. Must not be pregnant; or

3. Must meet one of the following criteria:

(i) Be sixty-five (65) years of age or older, or

(ii) Be blind, as defined in rule 1240-03-03-.02(3); or

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

(iii) Be disabled, as defined in rule 1240-03-03-.02(4); or

(iv) Be a "caretaker relative" of a Medicaid-eligible dependent child as defined in T.C.A. § 71-3-153; and

4. Must meet the financial eligibility criteria for income and resources that apply to Medically Needy pregnant women and children eligible under the State plan. These criteria are found at rules 1240-03-03-.05 and 1240-03-03-.06.

Authority: *T.C.A. §§4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106 and 71-5-109; 42 U.S.C.§ 1315, and 42 USC §1396 et seq., 42 USC §1396a(a)(10)(A)(ii); PL 100-485 §401; 42 USC §1396a(e)(4) and (1)(1); and 42 CFR §435.831, 42 C.F.R. § 435.210 and 42 C.F.R. § 435.201; and TennCare II Medicaid Section 1115 Demonstration Waiver.* ***Administrative History:*** *Original rule filed June 14, 1976; effective July 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed June 9, 1981; effective October 15, 1981. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed January 7, 1985; effective February 6, 1985. Amendment filed February 26, 1985; effective March 28, 1985. Amendment filed September 19, 1985; effective December 14, 1985. Amendment filed May 23, 1986; effective August 12, 1986. Amendment filed May 23, 1988; effective August 29, 1988. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed January 31, 1990; effective March 17, 1990. Amendment filed August 17, 1992; effective October 8, 1992. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed April 23, 1997; effective July 7, 1997. Amendment filed October 26, 2001; effective January 9, 2002. Repeal and new rule filed April 22, 2008; effective July 6, 2008.*

1240-03-02-.04 ENROLLMENT FOR STANDARD SPEND DOWN INDIVIDUALS.

(1) Transition Group enrollees not found eligible in an open category of Medicaid, will be selected for Standard Spend Down processing through the Request for Information (RFI) process. The TennCare waiver gives the State the authority to establish an enrollment cap and to limit open enrollment periods to the number of individuals who can be admitted under the cap.

(2) Categories for enrollment in the Standard Spend Down (SSD) program are as follows:

(a) Category 1. People who are not eligible for Medicaid at the time the SSD program is implemented and who meet the criteria for the new SSD program. (Bureau of TennCare will announce open enrollment for SSD).

(b) Category 2. People who, at the time the SSD program is implemented, are eligible for Medicaid in a non-pregnant adult Medically Needy category, who have completed their twelve (12) months of Medicaid eligibility, who have been found to be ineligible for any other Medicaid category, and who have been determined to meet the criteria of the SSD program.

(3) Applicants in the above categories will be enrolled as follows:

(a) Category 1 (applicants who will be allowed to apply when announced by the Bureau of TennCare) will be enrolled only through a single toll-free telephone point of entry (the Call-in Line) initiated in periods of acceptance of new applications. In each open enrollment period, the State will determine a specified number of calls that it will accept through the Call-in Line based on the number of Category 1 applications that, together with projected pending applications from Category 2, the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in open enrollment periods will also be based on the number of remaining slots available under the enrollment target and the number of slots necessary to reserve for non-pregnant

(Rule 1240-03-02-.04, continued)

Medically Needy adults in Category 2. The State will not accept or track calls received outside of open enrollment periods.

(b) For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their termination from Medicaid, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be accepted in the SSD category.

Upon implementation of the SSD program, the State will review all Category 2 individuals for either eligibility in a new Medicaid category or approval as a Standard Spend Down eligible. After the review of all Category 2 individuals is complete and it is determined how many additional enrollees can be added to the SSD program without exceeding the enrollment cap, the State will begin enrolling persons in Category 1.

(4) New open enrollment periods as announced by the Bureau of TennCare. Once the State has reached its targeted enrollment, new open enrollment periods will be scheduled when enrollment in the SSD program drops to ninety percent (90%) of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-in Line have been received. The number of calls to be received will be based on the State's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

(5) Initial application period for Category 1 (as announced by the Bureau of TennCare).

The State will establish an initial target enrollment figure based on the State's determination of the minimum number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions. A toll-free Call-in Line to receive requests for applications will be established and requests will be processed as follows:

(a) Callers to the Call-in Line will be asked for basic demographic information and will be assigned a unique identifier.

(b) After conducting a match to verify that callers are not already enrolled in TennCare Medicaid and if they are not Medicaid-eligible, the State will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within thirty (30) days. (Those callers who are already enrolled in TennCare Medicaid will be sent letters advising them that they currently have benefits and need not apply.)

(c) Completed signed applications received by the State by the 30-day deadline established by the State will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the State does not receive an application by the deadline, the State will send the individual a letter advising him or her that since no application was received, the State will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline.

(Rule 1240-03-02-.04, continued)

(d) Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a “waiting list” of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 C.F.R. 435.911; such timeframes will begin on the date a signed written application is received by the State.

(6) Effective date of eligibility. The effective date provisions outlined below only apply to SSD eligibility and do not apply to other categories of TennCare eligibility.

(a) The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-in Line and who submit a timely signed application will be the later of:

1. The date that their call was received by the Call-in Line; or

2. The date spenddown is met (which must be no later than the end of the one month budget period – in this case, the end of the month of the original call to the Call-in Line).

(b) The effective date of eligibility for the Transition Group is the later of:

1. The date of the application; or

2. The date that spenddown is met – in this case, the end of the month that the application is received by the Department of Human Services.

(c) The effective date of eligibility for Medically Needy pregnant women and children under age twenty-one (21) is the later of:

1. The date of application; or

2. The date that spenddown is met – in this case, the end of the month that the application is received by the Department of Human Services.

(7) Period of eligibility. All enrollees in the SSD demonstration category will have an eligibility period of twelve (12) months from the effective date of the eligibility. At the end of the 12-month period the enrollee will need to have his eligibility redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for Medically Needy pregnant women and children in TennCare Medicaid.

Authority: T.C.A. §§*4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102 and 71-5-109; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii), 42 U.S.C. § 1396a(e)(4) and 42 U.S.C. § 1315; and TennCare II Medicaid Section 1115 Demonstration Waiver.* ***Administrative History:*** *Original rule filed June 17, 1976; effective July 14, 1976. Amendment filed June 9, 1981; effective October 5, 1981. Amendment filed November 30, 1981; effective January 14, 1982. Repeal filed August 17, 1982; effective September 16, 1982. New rule filed April 22, 2008; effective July 6, 2008.*