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Emergency Rule Filing Form

Emergency rules are effective from date of filing for a period of up to 180 days.

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
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Rule Type:

Emergency Rule

Revision Type (check all that apply):

Amendment

New

Repeal

Statement of Necessity:

Pursuant to T.C.A. § 4-5-208, the Bureau of TennCare is authorized to adopt emergency rules in the event that the rules are required by an agency of the federal government and adoption of the rules through ordinary rulemaking procedures might jeopardize the loss of federal funds.

TennCare is implementing two new programs as required by federal law. The programs are RAC (Recovery Audit Contractor Program) and EHR-IP (Electronic Health Record Incentive Program). They share a common requirement of an appeals process for providers and a common start date: February 1, 2011.

The RAC Program required a Medicaid State Plan Amendment which has imposed an effective date of February 1, 2011, for an appeal process by which providers may appeal recovery actions resulting from the federally imposed audit process.

EHR-IP required an appeals process to be in place when the program is launched in each state. Tennessee is one of the leading states in implementing electronic health records and the process of enrolling providers in the funding program began on February 1, 2011. (NOTE: the funding is all federal dollars but the state Medicaid agency is required to control and disburse the funds.)

For a copy of these emergency rules contact: George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.



Darin J. Gordon
Director, Bureau of TennCare

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

Chapter Number	Chapter Title
1200-13-18	TennCare Administrative Actions and Provider Appeals
Rule Number	Rule Title
1200-13-18-.01	Scope and Authority
1200-13-18-.02	Definitions
1200-13-18-.03	Administrative Action for Recovery Under the Tennessee Medicaid False Claims Act
1200-13-18-.04	Recoupment or Withhold
1200-13-18-.05	Electronic Health Record Incentive Program (EHR-IP)
1200-13-18-.06	Termination or Exclusion of a Provider from Program Participation
1200-13-18-.07	Provider Sanctions

(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>)

Rules of the TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION Bureau of TennCare are amended by adding a new chapter 1200-13-18 TennCare Administrative Actions and Provider Appeals which shall read as follows:

Chapter 1200-13-18
TennCare Administrative Actions and Provider Appeals

1200-13-18-.01 Scope and Authority.

- (1) An approved provider of TennCare services may appeal the following administrative actions:
 - (a) An administrative action for recovery against a person other than an enrollee, recipient or applicant brought by the Bureau of TennCare upon written request of the Attorney General pursuant to the Tennessee Medicaid False Claims Act;
 - (b) An action proposed or taken by the Bureau of TennCare or its contractor to recover, recoup or withhold payment from a provider, including actions resulting from any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law;
 - (c) A denial of eligibility for or a determination of the amount of an incentive payment pursuant to the federal Affordable Care Act's Medicaid Electronic Health Record Incentive Program (EHR-IP); or,
 - (d) Termination of an approved provider's TennCare Provider Number by the Bureau, except when federal law mandates exclusion of the provider.
- (2) A provider of services may not appeal the following administrative actions:
 - (a) An MCC's refusal to contract with the provider;
 - (b) A decision by the Bureau to decline coverage of prescriptions not written by a provider with prescribing authority; or,
 - (c) Termination or exclusion from the Program as required by federal law.
- (3) In order to exercise the right to a hearing, a provider must submit his appeal and request for a hearing in writing to the Bureau. The notice of the Bureau action shall contain specific instructions concerning the right to appeal and the address for filing an appeal.

- (4) Any request for an appeal must be received at the address contained in the notice of action no later than 35 days following the date of the notice.
- (5) Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).
- (6) The Uniform Rules of Procedure for Hearing Contested Cases Before State Administrative Agencies, Chapter 1360-04-01, promulgated under the APA, are adopted by the Bureau and incorporated by reference herein. The Uniform Rules shall govern the conduct of a provider appeal except where a specific contrary provision is adopted by the Bureau in this Chapter.
- (7) For purposes of issuing an initial order, a contested case hearing shall be conducted by an administrative judge hearing the case alone.

Statutory Authority: T.C.A. §§ 4-5-208 and 71-5-105.

1200-13-18-.02 Definitions.

- (1) **Administrative Judge.** An employee or official of the Office of the Secretary of State who is licensed to practice law and authorized by law to conduct contested case proceedings.
- (2) **Administrative Procedures Act (APA).** The Tennessee Uniform Administrative Procedures Act, as amended, codified at T.C.A. §§ 4-5-301, et seq.
- (3) **Affordable Care Act (ACA).** The amendments made to Medicaid law by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, dispersed throughout Title XIX of the Social Security Act, codified in Title 42 of the United States Code.
- (4) **Approved Provider.** A provider of health care services who has registered with and been approved by the Bureau and has been issued a Tennessee Medicaid Provider Number.
- (5) **Audit.** The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program.
- (6) **Bureau of TennCare (Bureau).** The division of the Tennessee Department of Finance and Administration, the single state Medicaid agency, that administers the TennCare Program. For purposes of this Chapter, the Bureau shall represent the State of Tennessee.
- (7) **Civil Penalty.** A monetary penalty assessed by the Bureau against a provider in an amount of not less than \$1,000 nor more than \$5,000 for each violation of the Tennessee Medicaid False Claims Act. T.C.A. § 71-5-183(h)(3).
- (8) **Claim.** Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.
- (9) **Commissioner.** The chief administrative officer of the Tennessee Department where the Bureau is administratively located.
- (10) **Commissioner's Designee.** A person authorized by the Commissioner to review appeals of initial orders and to enter final orders pursuant to T.C.A. § 4-5-315, or to review petitions for stay or reconsideration of final orders.

- (11) **Contested Case.** An administrative proceeding in which the legal rights, duties or privileges of a party are required by any statute or constitutional provision to be determined by an agency after an opportunity for a hearing.
- (12) **Department.** The Tennessee Department of Finance and Administration.
- (13) **Electronic Health Record Incentive Program (EHR-IP).** The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide for incentive payments to eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified electronic health record (EHR) technology.
- (14) **Enrollee.** An individual eligible for and enrolled in the TennCare program.
- (15) **Error Rate.** The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term "error" does not indicate the intent of the person or entity submitting the claim.
- (16) **Findings of Fact.** The factual findings issued by the Administrative Judge or Commissioner's Designee following an administrative hearing. The factual findings are enumerated in the initial and/or final order. An order must include a concise and explicit statement of the underlying facts of record to support the findings.
- (17) **Final Agency Decision.** A Final Order.
- (18) **Final Order.** An initial order becomes a final order without further notice if not timely appealed, or if the initial order is appealed pursuant to T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a final order. A statement of the procedures and time limits for seeking reconsideration or judicial review shall be included with the issuance of a final order.
- (19) **Hearing.** A contested case proceeding.
- (20) **Initial Order.** The decision issued by the administrative judge following a hearing. The initial order shall contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It shall include a statement of the procedure for filing an appeal of the initial order as well as a statement of any circumstances under which the initial order may, without further notice, become a final order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review shall be included.
- (21) **Notice of Action.** The document or letter sent by the Bureau to a provider detailing the action the Bureau intends to take against the provider. The notice shall include a statement of the reasons and authority for the action as well as a statement of the provider's right to appeal the action, if applicable.
- (22) **Notice of Hearing.** The pleading filed with the Administrative Procedures Division by the Bureau upon receipt of an appeal. It shall contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and, a short and plain statement of the matters asserted, in compliance with the APA.
- (23) **Program.** See TennCare.
- (24) **Provider with Prescribing Authority.** A health care professional authorized by law or regulation to order prescription medications for her patients and who:
 - (a) Participates in the provider network of the MCC in which the beneficiary is enrolled; or
 - (b) Has received a referral of the beneficiary, approved by the MCC, authorizing her to treat the beneficiary; or,
 - (c) In the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.

- (25) **RAT-STATS.** A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.
- (26) **Standard of Proof.** A preponderance of the evidence.
- (27) **Statistically Valid Random Sampling.** A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.
- (28) **TennCare.** The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.
- (29) **Tennessee Medicaid Provider Number.** The identifying number issued by the Bureau to an approved provider for the purpose of receiving payment in exchange for rendering services to TennCare enrollees.
- (30) **Tennessee Medicaid False Claims Act (Act).** T.C.A. §§ 71-5-181, *et seq.*

Statutory Authority: T.C.A. §§ 4-5-208 and 71-5-105.

1200-13-18-.03 Administrative Action for Recovery Under the Tennessee Medicaid False Claims Act.

- (1) The Attorney General, following an investigation of a provider's claims, may determine that certain provider actions are appropriate for administrative action by the Bureau, pursuant to the Act. The Attorney General may refer any such matters to the Bureau Director, or his designee, along with the investigative file and a recommendation for action.
- (2) The Attorney General shall not refer matters originally brought under T.C.A. § 71-5-183(b) or if any person has the right to participate in or recover from the proceeding pursuant to T.C.A. § 71-5-183(c)(5).
- (3) Upon receipt of a written request from the Attorney General, the Bureau may commence a contested case proceeding on behalf of the State for recovery under the Act against any person other than an enrollee, recipient or applicant.
- (4) The Bureau may initiate the recovery process by notice of action to the provider setting out:
 - (a) The assessment of damages, civil penalties and related costs;
 - (b) The name and contact information of an individual within the Bureau with knowledge of the claim(s) and the assessment who is authorized to discuss the matter with the provider; and
 - (c) A statement of the right of the provider to appeal the assessment and the manner in which an appeal must be filed.
- (5) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (6) The Bureau may recover actual damages in an amount no greater than ten thousand dollars (\$10,000).
- (7) In addition to and not limited by the amount of actual damages, the Bureau may recover:
 - (a) Civil penalties of not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000) for each claim found to be in violation of the Act;
 - (b) Costs of the administrative action; and
 - (c) Treble the amount of actual damages.

- (8) Any action for recovery shall not be brought:
 - (a) More than six (6) years following the date on which the violation of the Act is committed; or
 - (b) More than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the state official charged with responsibility to act in the circumstances, but in no event not more than ten (10) years after the date the violation was committed, whichever occurs last.
- (9) A subpoena issued by an administrative judge pursuant to the APA requiring the attendance of a witness at a hearing may be served by certified mail at any place in the United States.
- (10) For purposes of rendering a final order pursuant to the APA, the Bureau is designated as the agency to review initial orders and issue final agency decisions. Orders issued by the Bureau shall have the effect of a final order pursuant to the APA.
- (11) Judgment. A final order issued by the Bureau under this rule may be enforced as a final judgment, as follows:
 - (a) A notarized copy of the final order must be filed in the office of the Clerk of the Chancery Court of Davidson County;
 - (b) Upon filing with the Clerk, a final order shall be considered as a judgment by consent of the parties on the same terms and conditions as those recited in the order;
 - (c) The judgment shall be promptly entered by the Court;
 - (d) The judgment shall become final on the date of entry; and
 - (e) A final judgment shall have the same effect, is subject to the same procedures and may be enforced or satisfied in the same manner as any other judgment of a court of record of the State of Tennessee.

Statutory Authority: T.C.A. §§ 4-5-208 and 71-5-105.

1200-13-18-.04 Recoupment or Withhold.

- (1) The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.
- (2) The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action. Each notice of action sent to a provider shall contain the proposed recovery action and the following information:
 - (a) The name and contact information of an individual knowledgeable about the audit findings and who is authorized to discuss the proposed recovery action with the provider;
 - (b) The manner by which the provider may submit additional information to support his disagreement with the proposed recovery action;
 - (c) A statement that the provider has the right to appeal the proposed recovery action and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (4) The audit and the audit findings are not subject to appeal. (See NHC v. Snodgrass, 555 S.W.2d 403 (Tenn. 1977)).

Statutory Authority: T.C.A. §§ 4-5-208 and 71-5-105.

1200-13-18-.05 Electronic Health Record Incentive Program (EHR-IP).

- (1) A TennCare provider, upon receipt of a notice of action, may appeal the following issues related to the EHR-IP:
 - (a) Denial of an incentive payment;
 - (b) Incentive payment amount;
 - (c) Determination of eligibility for an incentive payment, including but not limited to measurement of patient volume;
 - (d) Determination of meaningful use of certified EHR technology, including efforts to adopt, implement or upgrade to certified EHR technology;
 - (e) Whether the provider is hospital-based;
 - (f) Whether the provider is practicing predominantly in an FQHC or RHC;
 - (g) Whether a hospital qualifies as an acute care or children's hospital; or,
 - (h) Whether the provider is already participating in the Medicare incentive program and therefore is ineligible for duplicate TennCare incentive program payments.
- (2) Each notice of action sent to a provider of a determination of any matter listed in paragraph (1) shall contain the following:
 - (a) The name and contact information of an individual knowledgeable about the EHR-IP who is authorized to discuss the determination with which the provider disagrees;
 - (b) The manner by which the provider may submit additional information to support his disagreement with the determination; and
 - (c) A statement that the provider has the right to appeal the determination with which he disagrees and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

Statutory Authority: T.C.A. §§ 4-5-208 and 71-5-105.

1200-13-18-.06 Termination or Exclusion of a Provider from Program Participation

- (1) A provider may be terminated or excluded from participation in the TennCare program.
- (2) Federal Mandatory Exclusion. The Bureau is required by federal law to exclude a provider from participation in the TennCare program upon notice from HHS or CMS under the following circumstances:
 - (a) Conviction of program-related crimes;
 - (b) Conviction relating to patient abuse;
 - (c) Felony conviction relating to health care fraud; or
 - (d) Felony conviction relating to controlled substance.

- (3) Federal Permissive Exclusion. Pursuant to federal law, the Bureau may exclude a provider from participation in the TennCare program under the following circumstances:
- (a) Conviction related to fraud;
 - (b) Conviction related to obstruction of an investigation or audit;
 - (c) Misdemeanor conviction related to controlled substance;
 - (d) License revocation or suspension;
 - (e) Exclusion or suspension under federal or state health care program;
 - (f) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
 - (g) Fraud, kickbacks, and other prohibited activities;
 - (h) Entities controlled by a sanctioned individual;
 - (i) Failure to disclose required information;
 - (j) Failure to supply requested information on subcontractors and suppliers;
 - (k) Failure to supply payment information;
 - (l) Failure to grant immediate access;
 - (m) Failure to take corrective action;
 - (n) Default on health education loan or scholarship obligations;
 - (o) Individuals controlling a sanctioned entity; or
 - (p) Making false statements or misrepresentation of material facts.
- (4) When a provider exclusion is mandatory, the notice of action shall state that the provider has no right to appeal the termination from program participation.
- (5) When a provider exclusion is permissive, the notice of action shall include a statement that the provider has the right to appeal the termination from program participation and the manner in which an appeal must be filed.

Statutory Authority: T.C.A. §§ 4-5-208 and 71-5-105.

1200-13-18-.07 Provider Sanctions.

- (1) Pursuant to the authority granted by T.C.A. § 71-5-118 to the Commissioner to impose sanctions against providers, the Commissioner, through the Bureau, may take the following actions against a provider upon a finding that such actions will further the purpose of the Tennessee Medical Assistance Act:
- (a) Subject providers to stringent review and audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim;
 - (b) Refuse to issue or terminate a Provider Number if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program;

- (c) Refuse to issue or terminate a Provider Number if a determination is made that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs;
 - (d) Refuse to issue or terminate a Provider Number if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification;
 - (e) Refuse to issue or terminate a Provider Number upon notification by the U.S. Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation.
 - (f) Withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance; or,
 - (g) Recover from a provider any payments made by a recipient and/or his family for a covered service when evidence of recipient billing by the provider is determined by the Bureau and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from the Bureau to make repayment. If a provider knowingly bills a recipient and/or family for a TennCare covered service, in total or in part, except as otherwise permitted by State rules, the Bureau may terminate the provider from participation in the program.
- (2) In addition to the grounds for actions set out in T.C.A. § 71-5-118, activities or practices which justify sanctions against a provider and may include recoupment of monies incorrectly paid shall include, but not be limited to:
- (a) Noncompliance with contractual terms;
 - (b) Billing for a service in a quantity which is greater than the amount provided;
 - (c) Billing for a service which is not provided or not documented;
 - (d) Knowingly providing incomplete, inaccurate, or erroneous information to TennCare or its agent(s);
 - (e) Continued provision of poor record keeping or inappropriate or inadequate medical care;
 - (f) Medical assistance of a quality below recognized standards;
 - (g) Suspension from the Medicare or Medicaid program(s) by the authorized U.S. enforcement agency;
 - (h) Partial or total loss (voluntary or otherwise) of a provider's federal Drug Enforcement Agency (DEA) dispensing or prescribing certification;
 - (i) Restriction to or loss of practice by a state licensing board action;
 - (j) Acceptance of a pretrial diversion, in state or federal court, from a Medicaid or Medicare fraud charge or evidence from such charge;
 - (k) Violation of the responsible state licensing board license or certification rules;
 - (l) Conviction of any felony, any offense under state or federal drug laws, or any offense involving moral turpitude;
 - (m) Dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical or mental infirmity or disease;
 - (n) Dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if

I certify that this is an accurate and complete copy of an emergency rule(s), lawfully promulgated and adopted.



Date: 2/14/2011

Signature: [Handwritten 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: 2/14/11

Notary Public Signature: [Handwritten Signature]

My commission expires on: 9/31/2012

All emergency 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.

[Handwritten Signature]

Robert E. Cooper, Jr.
Attorney General and Reporter

2-17-11
Date

Department of State Use Only

Filed with the Department of State on: 2/18/11

Effective for: 180 *days

Effective through: 8/17/11

* Emergency rule(s) may be effective for up to 180 days from the date of filing.

[Handwritten Signature]

Tre Hargett
Secretary of State

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Impact on Local Governments

Pursuant to T.C.A. 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

There is no projected impact on local governments.

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;

This new Rule Chapter is being promulgated to provide TennCare with rules for an appeal process for providers.

- (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 Rule Chapter is lawfully adopted by the Bureau of TennCare in accordance with T.C.A. §§ 4-5-208 and 71-5-105.

- (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 persons most directly affected by this Rule Chapter are TennCare providers and the managed care contractors. The governmental entity most directly affected by this Rule Chapter is the Bureau of TennCare, 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;

This Rule Chapter was 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 this Rule Chapter 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, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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

None