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Emergency Rule Filing Form

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

Agency/Board/Commission:	Tennessee Department of Human Services
Division:	Medical Services
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Rule Type:
✔ Emergency Rule

Revision Type (check all that apply):
✔ Amendment
___ New
___ Repeal

Statement of Necessity:

In August 2009, approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for the new TennCare CHOICES in Long-Term Care Program was formally executed, allowing Tennessee to expand its Medicaid managed care system in order to provide eligible individuals with an integrated package of medical and long-term care benefits. This approval permits the Bureau to implement the Long-Term Care Community CHOICES Act of 2008, passed by the Tennessee General Assembly on May 20, 2008, and signed into law as Public Chapter 1190 on June 17, 2008. T.C.A. §§ 71-5-1401 et seq.

T.C.A. § 4-5-208(a)(4) permits an agency to adopt emergency rules when the agency finds that it is required by an agency of the federal government and adoption of the rules through ordinary rulemaking procedures might jeopardize the loss of a federal program or funds.

I have made a finding that the emergency adoption of amendments to Rule Chapters 1240-03-01, 1240-03-02 and 1240-03-03 is required in order to implement the Long-Term Care Community CHOICES Act of 2008 in a timely manner.

For a copy of this emergency rule, contact: Phyllis Simpson at the Department of Human Services by mail at Citizens Plaza Building, 400 Deaderick Street, 15th Floor, Nashville, Tennessee 37243-1403 or by telephone at (615) 313-4731.

Virginia T. Lodge

Commissioner, Department of Human Services

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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**
1240-03-01	General Rules
Rule Number	**Rule Title**
1240-03-01-.02	Definitions

Chapter Number	**Chapter Title**
1240-03-02	Coverage Groups Under Medicaid
Rule Number	**Rule Title**
1240-03-02-.02	Coverage of the Categorically Needy

Chapter Number	**Chapter Title**
1240-03-03	Technical and Financial Eligibility Requirements for Medicaid
Rule Number	**Rule Title**
1240-03-03-.02	Technical Eligibility Factors
1240-03-03-.03	Resource Limitations for Categorically Needy
1240-03-03-.04	Income Limitations for the Categorically Needy

Chapter 1240-03-01
General Rules

Amendments

Rule 1240-03-01-.02 Definitions, is amended by inserting "Bureau of TennCare", "CHOICES 217-Like Group", "CHOICES Group 1", "CHOICES Group 2", "CHOICES Member", "Enrollment Target", "Long-Term Care Program", "Medicare Savings Program", "Patient Liability", "Program of All-Inclusive Care for the Elderly (PACE)", "Statewide E/D Waiver", and "TennCare CHOICES in Long-Term Care", as new subparagraphs under paragraph (1) and by renumbering the existing subparagraphs, and by inserting new definitions for new subparagraphs (s) "Level 1 Nursing Facility care", (t) "Level 2 Nursing Facility care" and (aa) "Nursing Facility (NF)", so that as amended, paragraph (1) subparagraphs (a) through (nn) shall read as follows:

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

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

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

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

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

(f) CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility (NF) level of care criteria, who could have been eligible for Home and Community Based Services (HCBS) under 42 C.F.R. § 435.217 had the state continued its 1915(c) HCBS Waiver for persons who are elderly and/or

physically disabled, and who need and are receiving HCBS as an alternative to NF care. This group exists only in the Grand Divisions of Tennessee where the CHOICES Program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(y) Medicare. The Federal program under Title XVIII of the Social Security Act [42 U.S.C. §§ 1395 et seq.] providing medical benefits to persons receiving Social Security Retirement payments or who have received Social Security benefits based on disability for a period of twenty-four (24) consecutive months.

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

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

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

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

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

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

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

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

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

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

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

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

(hh) Qualified Medicare Beneficiary (QMB). A person who is eligible for Medicare Part A and for whom Medicaid pays the Medicare premium, coinsurance and deductible for Medicare covered services and whose income is not more than one hundred percent (100%) of the federal poverty level and resources are not more than twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple).

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

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

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

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

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

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

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. § 1396 et seq.; and Acts 2008, Chapter 1190.

Chapter 1240-03-02
Coverage Groups Under Medicaid

Amendments

Rule 1240-03-02-.02 Coverage of the Categorically Needy, is amended by deleting paragraph (2), subparagraph (f) in its entirety and by substituting instead the following language, so that, as amended, paragraph (2), subparagraph (f) shall read as follows:

(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:

(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.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. § 1396 et seq.; and Acts 2008, Chapter 1190.

Chapter 1240-03-03
Technical and Financial Eligibility
Requirements for Medicaid

Amendments

Rule 1240-03-03-.02 Technical Eligibility Factors, is amended by deleting subparagraph (a) under paragraph (9) and by substituting the following language, so that as amended, subparagraph (a) under paragraph (9) shall read as follows:

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

Rule 1240-03-03-.02 Technical Eligibility Factors, is amended by deleting paragraph (10) in its entirety and by substituting the following language, so that as amended, paragraph (10) shall read as follows:

(10) Institutionalized individuals in a medical institution (i.e., one organized to provide medical care, including nursing and convalescent care) must be likely to be continuously confined for at least thirty (30) consecutive days going forward, as evidenced by an approved NF Preadmission Evaluation eligibility segment which, when combined with the days already confined, total at least 30 days, prior to attaining Medicaid eligibility based on institutionalization. Medicaid eligibility in a NF is retroactive to the later of: a) the date of admission; or b) the date of application when thirty (30) consecutive days of institutionalization is met. Coverage of Home and Community Based Services (HCBS) offered either through CHOICES Program or through a Section 1915(c) of the Social Security Act HCBS waiver program requires a determination that the individual needs, and is likely to receive, HCBS services for thirty (30) consecutive days going forward. The effective date of eligibility in an HCBS program is the date of approval by DHS.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. 1396 et seq.; Acts 2008, Chapter 1190.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended at paragraph (2), subparagraph (a), part 1, subpart (i) to add the phrase "offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program" at the end of the second sentence, so that as amended, paragraph (2), subparagraph (a), part 1, subpart (i) shall read as follows:

(i) A homestead may be exempt if used as a home by the applicant/recipient, spouse, and/or dependent/relative. If absent from the home with intent to return, an individual may retain a homestead for an unlimited period of time. Based on current market values, individuals with an equity interest in their home greater than five hundred thousand dollars ($500,000) are ineligible for Medical assistance for either institutional care or Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program. Beginning in the year 2011, the five hundred thousand dollar ($500,000) limit on home equity will increase each year. The increase will be based on the percentage

increase in the Consumer Price Index (CPI) for all urban consumers, rounded to the nearest one thousand dollars ($1,000).

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, at paragraph (3), subparagraph (b) and (c) is amended by adding the phrase "offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program" in the first sentences respectively, so that as amended, paragraph (3), subparagraph (b) and (c) shall read as follows:

(b) The period of ineligibility for nursing home vendor or waivered services under HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program for assets transferred within sixty (60) months of application for long term care nursing services or HCBS will be determined by dividing the uncompensated value of the transferred asset by the average monthly nursing home private pay rate. In determining the penalty for a transfer a State may not round down or disregard any fractional period of ineligibility. There is no limit on the maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist and the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations and the application of the penalty will result in loss of essential nursing care, which is not available from any other source.

(c) If an asset has been found to be transferred for less than fair market value within the sixty (60) month look-back period, the penalty period begins the month the individual becomes eligible for institutional care or Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program or the month of the transfer, whichever is later. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a denial notice. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (3), subparagraph (e), part 4, subpart (ii) and by inserting new subparts (ii) and (iii), and renumbering the current subpart (iii) as subpart (iv), so that as amended, paragraph (3), subparagraph (e), part 4, subpart (ii), (iii) and (iv) shall read as follows:

(ii) The transfer of assets will be subject to a penalty period of ineligibility for nursing home vendor payments determined by dividing uncompensated value of the transferred asset by the average monthly nursing home charge at the private pay rate unless satisfactory proof is provided that the individual intended to dispose of assets for fair market value; or assets were transferred exclusively for a purpose other than to qualify for Medicaid; or transferred assets have been returned to the individual; or it is determined that the penalty period would work an undue hardship as defined in (3)(b) above.

(iii) Transfer of an asset for individuals enrolled in HCBS either through the CHOICES Program or through Section 1915(c) of the Social Security Act negates any eligibility under 42 C.F.R. § 435.217. The penalty for HCBS waiver recipients is the non-payment for waiver services, the receipt of which is an eligibility requirement for the HCBS category. The individual would remain ineligible until the look back period had expired, or until such time as he/she entered a nursing facility. Upon entry into a nursing

facility, the penalty period would commence and continue for the appropriate period of time.

(iv) Assets include all income and resources, including the home, unless transferred as indicated in (a) above, of the institutionalized individual and his/her spouse (including income and/or resources the individual is entitled to, but does not receive because of any action by the individual or his/her spouse, or a person (including a court) or administrative body with legal authority to represent the individual, his/her spouse, or who acts at the direction or request of the individual and his/her spouse).

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, at paragraph (8), subparagraphs (a), (b) and (c) is amended by adding the phrase "offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program" in the first sentences respectively. Parts 1 and 2 under subparagraph (c), paragraph (8) are not being amended. As amended, subparagraphs (a), (b) and (c) under paragraph (8) shall read as follows:

(a) Individuals who are receiving or will receive nursing facility services or home and community based services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and whose income exceeds the Medicaid Income Cap (MIC) may establish an income trust, referred to as a Qualified Income Trust (QIT) or "Miller Trust". Funds placed in a QIT that meets the standards set forth in paragraph (8) are not treated as available resources or income for purposes of determining the individual's TennCare eligibility.

(b) A QIT is a trust consisting only of the individual's pension income, Social Security Income, and other monthly income that is created for the purpose of establishing income eligibility for TennCare coverage when an individual is or soon will be confined to a nursing facility, HCBS or ICF/MR waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program.

(c) An individual is eligible to establish a QIT if his or her income is above the level at which he or she would be financially eligible for nursing facility, HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, or ICF/MR care under Medicaid.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. 1396 et seq.; Acts 2008, Chapter 1190.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (8), subparagraph (d), part 2, subpart (i) in the entirety and by substituting the following language, so that as amended, paragraph (8), subparagraph (d), part 2, subpart (i) shall read as follows:

(i) A personal needs allowance up to the amount recognized under Tennessee Medicaid policies. As of January 1, 2010, this amount is Fifty Dollars ($50) per month;

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, T.C.A. § 71-5-147; 42 U.S.C. § 1396a(q); and Acts 2009, Chapter 592, § 1.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, at paragraph (8), subparagraph (d), parts 3 and 4 is amended by adding the phrase "offered either through the

CHOICES Program or through a Section 1915(c) HCBS waiver program" in the first and second sentences respectively, so that as amended, paragraph (8), subparagraph (d), parts 3 and 4 shall read as follows:

3. Each month the Trustee shall distribute the entire amount of income remaining in the trust after any disbursements made under Part 2 above to the State of Tennessee, Bureau of TennCare (or directly to the nursing facility or HCBS provider or Managed Care Organization (MCO) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, as directed by the Bureau of TennCare), up to the total amount of expenditures for medical assistance for the Grantor.

4. The sole beneficiaries of the trust are the Grantor for whose benefit the trust is established and the State of Tennessee (Bureau of TennCare). The trust terminates upon the death of the Grantor, or if the trust is no longer required to establish Medicaid eligibility in the State of Tennessee, if nursing facility or HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program is no longer medically necessary for the Grantor, or if the Grantor is no longer receiving such services.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. 1396 et seq.; Acts 2008, Chapter 1190.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (9), subparagraph (b), part 1 to insert new figures, so that as amended, paragraph (9) subparagraph (b) part 1 shall read as follows:

1. Effective April 1, 2009 one-half (1/2) of the total resources owned by both spouses not to be less than twenty-one thousand nine hundred twelve dollars ($21,912) nor greater than one hundred nine thousand five hundred sixty dollars ($109,560) and adjusted annually per federal law;

Authority: T.C.A. §§ 4-5-201 et seq.; 4-5-202, and 4-5-208; and 42 U.S.C. § 1396r-5.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended by deleting subparagraph (a) under paragraph (2) in the entirety and by substituting instead the following language, so that as amended, paragraph (2), subparagraph (a) shall read as follows:

(a) Any aged, blind or disabled individual confined to long term nursing care in a facility must be likely to be continuously confined for at least thirty (30) consecutive days, as evidenced by an approved NF Preadmission Evaluation eligibility segment which, when combined with the days already confined, total at least 30 days, prior to attaining Medicaid eligibility or if enrolled in a HCBS waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and likely to receive HCBS services for at least 30 consecutive days going forward, may have countable income equal to or less than 300% of the SSI/FBR beginning the month of admission.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended by deleting subparagraph (b) part 1 under paragraph (2) and by substituting the following language, so that as amended, paragraph (2), subparagraph (b), part 1 shall read as follows:

(b) The otherwise eligible individual confined to a long-term care facility is required to assume some of his/her cost of care.

1. Personal Needs Allowance: $50 for an individual. The personal needs allowance for each person receiving Medicaid in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation is $50.

   (i) The maximum personal needs allowance for persons participating in CHOICES Group 2 is 300% of the SSI Federal Benefit Rate.

   (ii) The maximum personal needs allowance for persons participating in one of the State's Section 1915(c) HCBS waivers is as follows:

      (I) The Statewide HCBS E/D Waiver: 200% of the SSI Federal Benefit Rate.

      (II) The Statewide MR Waiver: 200% of the SSI Federal Benefit Rate.

      (III) The Arlington MR Waiver: 200% of the SSI Federal Benefit Rate.

      (IV) The Self-Determination MR Waiver: 300% of the SSI Federal Benefit Rate.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended to insert new figures in part 2 under paragraph (2), subparagraph (b). Subparts (i) through (iii) under part 2 under subparagraph (b) paragraph (2) are not being amended and will remain as they currently exist. As amended, part 2, under subparagraph (b) paragraph (2) shall read as follows:

2. Effective April 1, 2009, spousal dependent allocation not to exceed two thousand seven hundred thirty-nine dollars ($2,739) per family, and adjusted annually per federal law, which includes:

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended by deleting subparagraph (d) part 1 only, under paragraph (2). Parts 2 through 5 under subparagraph (d) of paragraph (2) are not being amended. As amended, paragraph (2), subparagraph (d), part 1 shall read as follows:

(d)

1. Personal Needs Allowance: $50 for an individual.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy is amended by deleting paragraph (3) only and inserting a new paragraph (3). Subparagraphs (a) through (c) under paragraph (3) are not being amended. As amended, paragraph (3) shall read as follows:

(3) Post-eligibility treatment of income for individuals participating in Home and Community Based Services (HCBS) offered either through CHOICES Program or through a Section 1915(c) of the Social Security Act HCBS waiver program will be determined as follows:

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. § 1396 et seq.; 42 U.S.C. § 1396a(q) and 42 U.S.C. § 1396r-5; and Acts 2008, Chapter 1190.

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

DEBRA E BATTS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires May 22, 2010

Date: March 1, 2010

Signature: [signature]

Name of Officer: Phyllis Simpson
Assistant General Counsel
Title of Officer: Tennessee Department of Human Services

Subscribed and sworn to before me on: March 1, 2010

Notary Public Signature: Debra E. Batts

My commission expires on: May 22, 2010

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.

Robert E. Cooper, Jr. by [signature]
Robert E. Cooper, Jr.
Attorney General and Reporter

March 1, 2010
Date

Department of State Use Only

Filed with the Department of State on: 3/1/10

Effective for: 180 *days

Effective through: 8/28/10

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

Tre Hargett
Tre Hargett
Secretary of State

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SECRETARY OF STATE
PUBLICATIONS

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 Medicaid 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 rule chapter is lawfully promulgated and adopted by the Department of Human Services 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 governmental entity most directly affected by this rule 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 rule 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;

Marcia Garner, Director, DHS Medicaid/TennCare Policy Marla Taylor, Program Manager, DHS Medicaid/TennCare Policy

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

Marcia Garner, Director, DHS Medicaid/TennCare Policy Marla Taylor, Program Manager, DHS Medicaid/TennCare Policy Phyllis Simpson, Assistant General Counsel, DHS

(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

Marcia Garner, Citizens Plaza Bldg, 12th Floor, Nashville, TN 37243 (615) 313-5465 Marcia.Garner@tn.gov Marla Taylor, Citizens Plaza Bldg., 12th Floor, Nashville, TN 37243 (615) 313-4873 Marla.Taylor@tn.gov Phyllis Simpson, Citizens Plaza Bldg., 15th Floor, Nashville, TN 37243 (615) 313-2269 Phyllis.Simpson@tn.gov

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

NONE

"REDLINE VERSION-RULE 1240-03-01-.02 DATED FEBRUARY 26, 2010"

RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-03-01
GENERAL RULES

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1240-03-01-01 Necessity and Functions 1240-03-01-.02 Definitions

1240-03-01-.02 DEFINITIONS.

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

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

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

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

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

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

(f) CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility (NF) level of care criteria, who could have been eligible for Home and Community Based Services (HCBS) under 42 C.F.R. § 435.217 had the state continued its 1915(c) HCBS

Waiver for persons who are elderly and/or physically disabled, and who need and are receiving HCBS as an alternative to NF care. This group exists only in the Grand Divisions of Tennessee where the CHOICES Program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(~~m~~s) ~~Level I care. Level I care is health care in a nursing facility which is more than room and board, but is less than skilled nursing care. (Level I care was formally called I.C.F. - Intermediate Care Facility).~~ Level 1 Nursing Facility care. The level of Medicaid reimbursement provided for nursing facility services delivered to residents eligible for Medicaid-reimbursement of NF services determined by TennCare to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(4) by a NF that meets the requirements set forth in Rule 1200-13-01-.03, and in accordance with the reimbursement methodology for Level 1 NF Care set forth in Rule 1200-13-01-.03.

(~~n~~t) ~~Level II care. Level II care is health care in a nursing facility which is a higher level of care than Level I, but less than inpatient hospitalization. (Level II care was formally called Skilled Nursing Care.)~~ Level 2 Nursing Facility care. The level of Medicaid reimbursement provided for nursing facility services delivered to residents eligible for Medicaid-reimbursement of NF services determined by TennCare to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5) by a NF that meets the requirements set forth in Rule 1200-13-01-.03, and in accordance with the reimbursement methodology for Level 2 NF Care set forth in Rule 1200-13-01-.03.

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

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

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

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

(~~r~~y) Medicare. The Federal program under Title XVIII of the Social Security Act [42 U.S.C. §§ 1395 et seq.] providing medical benefits to persons receiving Social Security Retirement payments or who have received Social Security benefits based on disability for a period of twenty-four (24) consecutive months.

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

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

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

(~~s~~aa) Nursing Facility (NF). A Medicaid-certified NF approved by the Bureau of TennCare. ~~A facility certified by the State to provide nursing care in what was formally called Intermediate Care Facility (I.C.F.) and Skilled Nursing Facility (S.N.F.).~~

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

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

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

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

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

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

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

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

(~~x~~hh) Qualified Medicare Beneficiary (QMB) – A person who is eligible for Medicare Part A and for whom Medicaid pays the Medicare premium, coinsurance and deductible for Medicare covered services and whose income is not more than one hundred percent (100%) of the federal poverty level and resources are not more than twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple).

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

(~~z~~jj) Specified Low-Income Medicare Beneficiary (SLMB) - A person who is eligible for Medicare Part A and for whom Medicaid pays Medicare Part B premiums, if income is not more than one hundred twenty percent (120%) of the federal poverty level and resources are not more than twice the SSI limit ($4,000 for an individual, $6,000 for a couple).

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

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

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

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

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

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

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

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

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

1. TennCare Medicaid enrollees; or

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

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

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

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

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

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

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

(g) TennCare Standard. That part of the TennCare program which provides coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules and those of the TennCare Bureau.

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

Authority: *T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-3-153, 71-3-158(d)(2)(D), 71-5-101, 71-5-103 and 71-5-111; Acts 2007, Ch 31, § 11; 42 U.S.C. § 423, 42 U.S.C. §§ 601 et seq.; 42 U.S.C. §§ 1382 et seq.; 42 U.S.C. §§ 1395 et seq.; 42 US.C. § 1395i-2a] 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(E); 42 U.S.C. § 1396a(e)(4); 42 U.S.C. § 1396d(p)(1), (2) and (3), 42 U.S.C. § 1396d(s); 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5), 42 U.S.C. § 1396r and 42 U.S.C. § 1396u-1; 42 C.F.R. § 435.4; 45 C.F.R. § 233.90(c); PL 101-508 § 5103(e); PL 98-21 § 134, PL 100-203 § 9116, PL 104-193, and PL 109-171 § 6021; and TennCare II Medicaid Section 1115 Demonstration Waiver.* ***Administrative History:*** *Original rule filed June 14, 1976; effective July 14, 1976. Amendment filed April 23, 1997; effective July 7, 1997. Public necessity rule filed July 2, 2007; effective through December 14, 2007. Amendment filed*

"REDLINE VERSION-RULE 1240-03-01-.02 DATED FEBRUARY 26, 2010"

September 25, 2007; effective December 9, 2007. Public necessity rule filed January 24, 2008; effective through July 7, 2008. Amendment filed April 22, 2008; effective July 6, 2008. Amendment filed February 24, 2009; effective May 10, 2009. Amendment filed August 5, 2009; effective November 3, 2009.

"REDLINE VERSION-RULE 1240-03-02-.02 DATED FEBRUARY 26, 2010"

RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-03-02
COVERAGE GROUPS UNDER MEDICAID

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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.

(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) ~~under a waiver pursuant to~~ 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:

(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.

(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 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, 71-1-105(12), 71-3-158(d)(2)(D), 71-5-102, 71-5-106, and 71-5-109; Acts 2007, Chapter 31 § 11; 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.*

"REDLINE VERSION-RULES 1240-03-03-.02, -.03 and -.04 DATED MARCH 1, 2010"

RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-03-03
TECHNICAL AND FINANCIAL ELIGIBILITY
REQUIREMENTS FOR MEDICAID

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1240-03-03-.02 TECHNICAL ELIGIBILITY FACTORS. To be eligible for Medicaid, families or individuals, whether classified as Categorically Needy or Medically Needy, must meet the following requirements, where applicable:

(1) Children otherwise covered under 1240-03-02-.02(3) or adults must not be inmates of a public institution, as that term is defined by Federal regulations and policy.

(2) An aged individual must be at least 65 years of age.

(3) A blind individual must meet the definition of blindness as contained in Title II and XVI of the Social Security Act relating to OASDI and SSI, 42 C.F.R. §435.530.

(4) A disabled individual must meet the definition of permanent and total disability as contained in Titles II and XVI of the Social Security Act relating to OASDI and SSI. Eligibility based on disability is determined in accordance with requirements set out by Titles XVI and XIX of the Social Security Act , 42 C.F.R. §§435.540, 435.541, and 435.911. As Tennessee is a 1634 State, the disability decision made by the Social Security Administration (SSA) for Supplemental Security Income (SSI) applicants is binding on the State Agency's decision for Medicaid only based on disability except when the individual applies for:

(a) Medicaid only and has not applied for SSI or has applied for SSI but was ineligible for a reason other than disability; or

(b) SSI at the Social Security Administration and applies to the State Agency for Medicaid only and the Social Security Administration does not make a disability determination within 90 days from the date of application for Medicaid only; or

(c) Medicaid only and alleges that a different or additional disabling condition exists and was not considered by the Social Security Administration; or

(d) Medicaid only more than 12 months after SSI disability denial and alleges that the disabling condition has changed or deteriorated or applies in less than 12 months of the Social Security Administration's determination alleging his/her condition has changed/deteriorated but the Social Security Administration refused to consider these new allegations and/or he/she is no longer financially or technically (other than disability) eligible for SSI.

(5) An individual must be a citizen of the United States, a naturalized citizen, certain American Indians born outside of the United States, or a qualified alien, unless applying for emergency medical services assistance as an illegal or undocumented alien or one lawfully admitted for residence who is not aged, blind, disabled, or under age eighteen (18). Aliens who entered the United States on or after August 22, 1996 have a five (5) year bar before potential eligibility for TennCare Medicaid unless they meet the exceptions to the five (5) year bar as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

(a) Each applicant/recipient is required to provide documentary evidence of citizenship and identity when applying for medical assistance. This requirement shall not apply to an individual declaring to be a citizen or national of the United States if they are:

1. A recipient of Medicare; or

2. A recipient of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI); or

3. A child who is a recipient of foster care or adoption assistance under Title IV-B of the Social Security Act; or

4. A child who is a recipient of foster care or adoption assistance under Title IV-E of the Social Security Act.

(b) All documents must be originals or certified by the issuing agency.

(6) A child up to age twenty-one (21) or a pregnant woman.

(7) An individual must be a resident of the State of Tennessee, as defined by federal regulations at 42 C.F.R. § 435.403, Tennessee Code Annotated § 71-5-120, and as further defined by the Bureau of TennCare.

(8) By accepting medical assistance through the Medicaid program, every recipient is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Failure to cooperate in establishing the paternity of dependent children, or in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating medical eligibility.

(9) Asset Disregards for Qualifying Long Term Care Insurance Policies

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare ~~Medicaid~~. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

(b) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.

(c) Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery. When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were

disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above, even if a qualified long term care policy's benefits were not completely exhausted.

(10) Institutionalized individuals in a medical institution (i.e., one organized to provide medical care, including nursing and convalescent care) must be likely to be continuously confined for at least thirty (30) consecutive days going forward, as evidenced by an approved NF Preadmission Evaluation eligibility segment which, when combined with the days already confined, total at least 30 days, prior to attaining Medicaid eligibility based on institutionalization. Medicaid eligibility is retroactive to the later of: a) the date of admission; or b) the date of application when thirty (30) consecutive days of institutionalization is met. Coverage of Home and Community Based Services (HCBS) offered either through CHOICES Program or through a Section 1915(c) of the Social Security Act HCBS waiver program requires a determination that the individual needs, and is likely to receive, HCBS services for thirty (30) consecutive days going forward. The effective date of eligibility in an HCBS program is the date of approval by DHS.

(11) As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance.

Authority: *T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, 71-5-107, 71-5-109, 71-5-120 and 71-5-141; 8 U.S.C. §§ 1611, 1612, 1613, and 1641, 42 U.S.C. § 402, 42 U.S.C. § 423, 42 U.S.C. § 672, 42 U.S.C § 673, 42 U.S.C. § 1315, 42 USC §§ 1382c(a)(3) and (4), 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii)(I) and (V)(VI); 42 U.S.C. § 1396b(v)(1) and (x)(1), (2) and (3); 42 U.S.C. § 1396d and 42 U.S.C. 1396n(c); 1396(b)(1)(C)(iii) and (b)(5); 42 C.F.R. §§ 435.210, 435.217, 435.300, 435.301, 435.403, 435.406, 435.407, 435.530, 435.540, 435.622, and 435.914(c); PL 104-193 §§ 401, 402, 403 and 431, PL 109-432, Division B, Title IV § 405, December 20, 2006, and PL 109-171 § 6036, 6021; 71 FR 39214 (July 6, 2006); and TennCare Medicaid Section 1115 Demonstration Waiver.* ***Administrative History:*** *Repeal and new 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 5, 1981. Amendment filed August 28, 1981; effective November 30, 1981. Amendment filed November 30, 1981; effective January 14, 1982. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed September 4, 1984; effective October 4, 1984. Amendment filed September 19, 1985; effective October 19, 1985. Amendment filed May 23, 1986; effective August 12, 1986. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed August 17, 1992; effective October 8, 1992. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed June 5, 1995; effective August 18, 1995. Amendment filed May 1, 2003; effective July 15, 2003. Public Necessity Rule filed June 1, 2007; expired November 13, 2007. Public necessity rule filed July 2, 2007; effective through December 14, 2007. Amendment filed August 30, 2007; effective November 13, 2007. Amendment filed December 11, 2007; effective February 24, 2008. Amendments filed April 22, 2008; effective July 6, 2008. Amendment filed February 24, 2009; effective May 10, 2009.*

"REDLINE VERSION-RULES 1240-03-03-.02, -.03 and -.04 DATED MARCH 1, 2010"

1240-03-03-.03 RESOURCE LIMITATIONS FOR CATEGORICALLY NEEDY.

(1) Applicants for medical assistance as Categorically Needy in an AFDC related coverage group are permitted to retain resources as described in rule 1240-01-50-.02 pertaining to the Families First/AFDC cash assistance program. Excluded resources are those excluded in the Families First/AFDC cash assistance program as reflected in rule 1240-01-50-.05 and countable resources are determined by using the Families First/AFDC policy reflected in rule 1240-01-50-.06. Lump sum payments are treated as income in the month of receipt and a resource if retained thereafter.

(2) Applicants for medical assistance as Categorically Needy in an SSI-related category are permitted to retain resources in an amount not to exceed SSI limits except for Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals 1 (QI1) (also referred to as Specified Low-Income Beneficiaries (SLIBs)), and Qualified Disabled Working Individuals who are permitted to retain resources in an amount not to exceed two hundred percent (200%) of the SSI limits.

(a) Resources excluded from consideration in determination of eligibility for medical assistance are:

1. For SSI related cases (aged, blind, and disabled individuals):

(i) A homestead may be exempt if used as a home by the applicant/recipient, spouse, and/or dependent/relative. If absent from the home with intent to return, an individual may retain a homestead for an unlimited period of time. Based on current market values, individuals with an equity interest in their home greater than five hundred thousand dollars ($500,000) are ineligible for Medical assistance for either institutional care or Home and Community-_Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program. Beginning in the year 2011, the five hundred thousand dollar ($500,000) limit on home equity will increase each year. The increase will be based on the percentage increase in the Consumer Price Index (CPI) for all urban consumers, rounded to the nearest one thousand dollars ($1,000).

(ii) All life insurance, if the total face of all policies does not exceed fifteen hundred dollars ($1500) per owner.

(iii) One motor vehicle of unlimited value is excluded in its entirety, if it meets any one of the following conditions:

(I) It is necessary for employment; or

(II) It is necessary to obtain medical treatment of a specific or regular medical problem; or

(III) It has been modified for operation by or transportation of a handicapped person; or

(IV) It is necessary because of climate, terrain, distance, or similar factors to provide transportation to perform essential daily activities.

I. If no motor vehicle is excluded under the above provisions, one motor vehicle is excluded to the extent equity value does not

exceed forty-six hundred dollars ($4,600). If the equity value exceeds forty-six hundred dollars ($4,600), the excess is counted against the resource limit.

II. The equity value of any other motor vehicle is counted unless also excludable under 1240-03-03-.03(2)(a)1(iii) above or qualified as property under an approved plan for self-support or necessary for self-support in a business or non-business income producing activity. If no motor vehicle is excluded under the above provisions, one motor vehicle is excluded to the extent equity value does not exceed forty-six hundred dollars ($4,600). If the equity value exceeds forty- six hundred dollars ($4,600), the excess is counted against the resource limit.

III. The equity value of any other motor vehicle is counted unless qualified as property under an approved plan for self-support or necessary for self-support, in a business or non-business income producing activity, or fifteen hundred dollars ($1,500) of the equity value is set aside for burial reserve.

(iv) Personal effects and household goods of two thousand dollars ($2,000) or less equity value.

(v) Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools etc.) used in a trade or business; nonbusiness income-producing property (such as, houses or apartments for rent, land other than home property, etc.); and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as a part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualified under the home exclusion (1240-03-03-.03(2)(a)1(i) above), it is not considered in evaluating property essential to self-support.

(I) Property used in a trade or business or nonbusiness income-producing activity.

I. When property is used in a trade or business or nonbusiness income-producing activity, only the individual's (or spouse, if any) equity in the property is counted. Exclude as essential for self-support up to six thousand dollars ($6,000) in equity and count only the amount that exceeds six thousand dollars ($6,000), if the net income totals at least six percent (6%) of the equity.

II. If the work activity produces less than a six percent (6%) rate of return due to circumstances beyond the individual's control such as due to illness or crop failure and the individual is expected to resume the activity, the equity up to six thousand dollars ($6,000) continues to be excluded. If the individual's total equity in the property is producing six percent (6%) income but is over the six thousand dollars ($6,000) equity limit, the amount of equity exceeding the six thousand dollars ($6,000) is counted as a resource.

III. If the individual owns more than one (1) piece of property and each produces income, each is looked at to see if the six percent (6%) rule is met and then the amounts of the individual's equity in all of those properties producing six percent (6%) are totaled to see if the total equity is six thousand dollars ($6,000) or less. The equity in those properties that do not meet the six percent (6%) rule is counted toward the allowable resource limit of two thousand dollars ($2,000) for an individual. If the total equity in the properties producing six percent (6 %) income is over the six thousand dollars ($6,000) equity limit, the amount of equity exceeding six thousand dollars ($6,000) is counted as a resource toward the allowable resource limit.

Example: Charlotte operates a farm. She owns 3 acres of land on which her home is located. She also owns 10 acres of farm land not connected to her home. There are 2 tool sheds and 2 animal shelters located on the 10 acres. She has various pieces of farm equipment that are necessary for her farming activities. We exclude the house and the 3 acres under the home exclusion (20 C.F.R. § 416.1212). However, we look at the other 10 acres of land, the buildings and equipment separately to see if her total equity in them is no more than $6,000 and if the annual rate of return is 6 percent of her equity. In this case, the 10 acres and buildings are valued at $4,000 and the few items of farm equipment and other inventory are valued at $1,500. Charlotte sells produce which nets her more than 6 percent for this year. The 10 acres and other items are excluded as essential to her self-support and they continue to be excluded as long as she meets the 6-percent annual return requirement and the equity value of the 10 acres and other items remains less than $6,000.

Additional Example: At redetermination, Mr. Jones (the community spouse) states he now lives in an apartment and has rented the couple's formerly excluded homestead which has an equity value of $10,000. Although, the property produces a 6% rate of return, $4,000 of its equity cannot be excluded under this subpart (v).

(II) Property that represents government authority to engage in an income-producing activity.

I. Property that represents the authority granted by a governmental agency to engage in an income-producing activity is excluded as property essential to self-support if it is used in a trade or business or nonbusiness income-producing activity or not used due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.

Example: John owns a commercial fishing permit granted by the State Commerce Commission, a boat and fishing tackle. The boat and tackle have an equity value of $6,500. Last year,

John earned $2,000 from his fishing business. The value of the fishing permit is not determined because the permit is excluded under the exception. The boat and tackle are producing in excess of a 6 percent return on the excluded equity value, so they are excluded up to $6,000. The $500 excess value is counted toward the allowable resource limit of $2,000 for an individual.

(III) Property required by employer.

I. Personal property required by the individual's employer for work is not counted regardless of value, while the individual is employed. Examples of this type of personal property include tools, safety equipment, uniforms and similar items.

(IV) Property used to produce goods or services essential to daily activities.

I. Nonbusiness property is considered to be essential for an individual's (and spouse, if any) self-support if it is used to produce goods or services necessary for his or her daily activities. This type of property includes real property such as land which is used to produce vegetables or livestock only for personal consumption in the individual's household (for example, corn, tomatoes, chicken, cattle). Property used to produce goods or services or property necessary to perform daily functions is excluded if the individual's equity in the property does not exceed six thousand dollars ($6,000).

For example: Bill owns a small unimproved lot several blocks from his home. He uses the lot, which is valued at $4,800, to grow vegetables and fruit only for his own consumption. Since his equity in the property is less than $6,000, the property is excluded as necessary to self-support.

(vi) Burial space for self, spouse and immediate family members.

(I) Burial space is defined to include conventional grave sites, crypts, mausoleums, urns, or other repositories which are customarily and traditionally used for the remains of deceased persons.

(II) Immediate family includes the applicant's or recipient's minor and adult children, step-children, adopted children, brothers, sisters, parents, adoptive parents, and spouses of these persons.

(vii) Funds used to purchase a promissory note, loan or mortgage, if the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan with no deferrals or balloon payments, and the balance is not cancelled upon the death of the lender.

(viii) Funds used to purchase a promissory note, loan or mortgage, if the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan with no deferrals or balloon payments, and the balance is not cancelled upon the death of the lender.

(ix) Funds, which are not commingled, are subject to the limits specified below, which are designated as set aside for expenses connected with the individual's burial, cremation or other funeral arrangements.

(I) The maximum revocable amount which may be set aside is fifteen hundred dollars ($1,500) for the applicant/recipient and fifteen hundred dollars ($1,500) for his/her spouse.

(II) The maximum revocable amount is reduced by an amount equal to funds held in an irrevocable burial trust, contract or agreement.

(III) The maximum irrevocable burial fund, agreement or contract established by the individual is six thousand dollars ($6,000) plus cost of transporting the body.

(IV) Irrevocable burial contract or agreements established by a funeral home/director for an individual must be a reasonable amount and must have an itemized list of costs, goods and services that reflect fair market value.

(x) Other resources determined to be unavailable to the applicant/recipient due to circumstance beyond his/her control.

(b) In SSI related cases all other resources such as, but not limited to bank accounts, money on hand, stocks, bonds, cash value of life insurance on which the total face value exceed fifteen hundred dollars ($1,500), real property, other than income-producing and homestead property (including cemetery plots) not exempt in 1240-03-03-.03(2)(a)1(i) and (v), non-excluded motor vehicles and revocable burial agreements, unless exempt as in 1240-03-03-.03(2)(a)1(iii) and (viii) shall be counted toward the resource limit per family size.

(c) Resource eligibility will exist for the entire month, if the applicant/recipient's total countable resources are at or below the resource limit at any time during the month in question.

(3) Transfer of Assets.

(a) Countable assets under this paragraph (3) include all real and personal property except a home and title transferred to the individual's--

1. Spouse;

2. Minor child under age twenty-one (21) or adult disabled or blind child;

3. Sibling who has equity interest in the property and has resided in the home for at least one (1) year prior to the individual's institutionalization;

4. Child [other than those in part 2 above] who resided in the home at least two (2) years immediately preceding the individual's institutionalization and who provided care that permitted the individual to stay in the home rather than a medical or nursing facility; or

5. To another for the sole benefit of the community spouse or the individual's child who is blind or permanently and totally disabled, or under age twenty-one (21).

(b) The period of ineligibility for nursing home vendor or waivered services under HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program for assets transferred within sixty (60) months of application for long term care nursing services or HCBS will be determined by dividing the uncompensated value of the transferred asset by the average monthly nursing home private pay rate. In determining the penalty for a transfer a State may not round down or disregard any fractional period of ineligibility. There is no limit on the maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist and the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations and the application of the penalty will result in loss of essential nursing care, which is not available from any other source.

(c) If an asset has been found to be transferred for less than fair market value within the sixty (60) month look-back period, the penalty period begins the month the individual becomes eligible for institutional care or Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program or the month of the transfer, whichever is later. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a denial notice. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.

(d) Any multiple transfers made within the look-back period will be treated as a single transfer and calculated as a single period of ineligibility, which would begin on the date the individual is eligible for medical assistance and would otherwise be receiving institutional level care if not for the imposition of the penalty period, or the date of transfer, whichever is later. For example, if an individual's spouse makes an uncompensated transfer of assets of one thousand dollars ($1,000) in each of the sixty (60) months of the look-back period, the State would add the transfers together to arrive at a total amount of sixty thousand dollars ($60,000), divide that by the average private pay rate, and impose one continuous period of ineligibility. The penalty period would start with the earliest date specified under Tennessee's Medicaid plan.

(e) The transfers indicated below, if occurring on or after February 8, 2006, may be considered a transfer of assets for less than fair market value with respect to an individual applying for Medicaid based on institutionalization:

1. If the transfer of assets occurs within sixty (60) months of application for institutional care.

2. If the institutionalized individual, his/her spouse, or any person, court or administrative body with authority to act on behalf of, or at the direction or request of, the individual or his/her spouse, establishes a trust or similar device, which includes the individual's assets and cannot be used by or for the individual's benefit, if it occurred within sixty (60) months of application for institutional care.

3. If an asset is held jointly by the institutionalized individual with another person and the individual or other owner reduces or eliminates the institutionalized individual's ownership or control of the asset.

4. Penalty.

   (i) The institutionalized individual may be subject to penalty if the transfer was completed by himself/herself; the individual's spouse; a person (including a court) or administrative body with legal authority to act in place of, or on

behalf of, or at the direction or request of the institutionalized individual or his/her spouse.

(ii) The transfer of assets will be subject to a penalty period of ineligibility for nursing home vendor ~~or waivered services under HCBS (Medicaid eligibility continues for other services)~~ payments determined by dividing uncompensated value of the transferred asset by the average monthly nursing home charge at the private pay rate unless satisfactory proof is provided that the individual intended to dispose of assets for fair market value; or assets were transferred exclusively for a purpose other than to qualify for Medicaid; or transferred assets have been returned to the individual; or if it is determined that the penalty period would work an undue hardship as defined in (3)(b) above.

(iii) Transfer of an asset for individuals enrolled in HCBS either through the CHOICES Program or through Section 1915(c) of the Social Security Act negates any eligibility under 42 C.F.R. § 435.217. The penalty for HCBS waiver recipients is the non-payment for waiver services, the receipt of which is an eligibility requirement for the HCBS category. The individual would remain ineligible until the look back period had expired, or until such time as he/she entered a nursing facility. Upon entry into a nursing facility, the penalty period would commence and continue for the appropriate period of time.

(~~iii~~iv) Assets include all income and resources, including the home, unless transferred as indicated in (a) above, of the institutionalized individual and his/her spouse (including income and/or resources the individual is entitled to, but does not receive because of any action by the individual or his/her spouse, or a person (including a court) or administrative body with legal authority to represent the individual, his/her spouse, or who acts at the direction or request of the individual and his/her spouse).

(f) Any contractual provision requiring the resident to deposit entrance fees must take into account the required allocation of resources or income to the community spouse before determining the resident's cost of care. In addition the entrance fee paid to the Continuing Care Retirement Community (CCRC) or life care community is treated as a resource to an individual for purposes of determining Medicaid eligibility. The following three (3) conditions must all be met in order for the entrance fee to be considered an available resource:

1. Any portion of the entrance fee is refunded or used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient; and

2. The entrance fee, or any portion thereof, is refundable under the terms of the contract when the individual dies or terminates the contract and leaves the CCRC or life care community, whether or not any amount is actually refunded; and

3. The entrance fee does not confer an ownership interest in the community.

(g) Funds used to purchase a loan, mortgage or promissory note must be treated as a transfer of assets unless it has a repayment term that is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral or balloon payment, and prohibits cancellation of the balance upon the death of the lender. If an individual purchases a home from a nursing home applicant and the purchase

agreement does not meet the criteria of this subparagraph (g), the value of the home will be the outstanding balance due as of the date of the application for Medicaid.

(h) A life estate interest purchased by a nursing home applicant in another individual's home shall be treated as a transfer of assets unless the nursing home applicant resides in the home for a period of at least one (1) year after the date of the purchase.

(4) Funds paid into irrevocable burial agreements that are in compliance with *T.C.A. §62-5-401 et seq.* are not counted as a resource. The agreement must be irrevocable as provided in *T.C.A. §62-5-403(a)(2).*

(5) Medicaid Qualifying Trust.

(a) Funds from a Medicaid qualifying trust, as defined below, are deemed to be available to the applicant/recipient as provided below when an application for Medicaid is filed on or after June 1, 1986 and a countable resource to that applicant/recipient.

(b) For purposes of this rule, a "Medicaid qualifying trust" is a trust, or similar legal device, established prior to August 11, 1993 (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(c) The amounts from the trust deemed available to an applicant/recipient is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the applicant/recipient, assuming full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the applicant recipient.

(d) The provisions of this paragraph shall apply without regard to:

1. Whether or not the Medicaid qualifying trust is irrevocable or is established for purposes other than to enable an applicant/recipient to qualify for Medicaid; or

2. Whether or not the discretion described in subparagraphs (b) and (c) is actually exercised.

(6) Undue hardship shall exist when an application of a transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered or of loss of food, clothing, shelter, or other necessities of life.

(a) The individual, the individual's responsible party, or the facility in which an institutionalized individual resides may file an undue hardship claim on behalf of the applicant/recipient. DHS will determine whether a hardship exists and notify the applicant/recipient within thirty (30) days of filing.

(b) If undue hardship is determined not to exist, the denial of undue hardship may be appealed within forty (40) days.

(c) While an application is pending for an undue hardship waiver and the applicant meets the criteria in 1240-03-03-.03 (6) above, the state will provide for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of ten (10) days.

(7) Annuities.

(a) For any new application or recertification for medical assistance for long-term care services, the applicant must include a description and disclosure of any interest the applicant or the community spouse may have in an annuity.

(b) The annuity must be treated as a transfer of assets unless it is irrevocable and non-assignable, actuarially sound, and provides payments in equal amounts during the term of the annuity, with no deferral or balloon payments.

(c) The purchase of an annuity will be treated as a transfer of assets for less than fair market value unless:

1. The State of Tennessee is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant. This provision applies to annuities purchased by an applicant or by a spouse, or transactions made by the applicant or spouse.

2. If there is a community spouse and/or a minor or disabled child, the State is named in the next position after those individuals.

(i) If the State has been named after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State may then be named in the first position.

(ii) A child is considered disabled if he or she meets the definition of disability found at Section 1614(a)(3) of the Social Security Act (42 U.S.C. § 1382c(a)(3)).

(d) In addition to the provisions in (c)1 or 2 above, an annuity purchased by or on behalf of the annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions in part 1 or part 2 or all of the conditions in part 3 below.

1. The annuity is –

(i) An individual retirement annuity according to section 408(b) of the Internal Revenue Code of 1986 (IRC) (26 U.S.C. § 408(b)), or

(ii) Deemed Individual Retirement Account (IRA) under a qualified employer plan according to section 408(q) of the IRC (26 U.S.C. § 408(q)), or

2. The annuity is purchased with proceeds from –

(i) A traditional IRA (IRC § 408(a) (26 U.S.C. § 408(a)), or

(ii) Certain accounts or trusts which are treated as traditional IRAs (IRC § 408 (c)) (26 U.S.C. § 408(c)), or

(iii) Simplified retirement account (IRC § 408 (p)) (26 U.S.C. § 408(p)), or

(iv) A simplified employee pension (IRC § 408 (k)) (26 U.S.C. § 408(k)), or

(v) A Roth IRA (IRC § 408 A) (26 U.S.C. § 408(A)), or

3. The annuity meets all of the following—

   (i) The annuity is irrevocable and non-assignable,

   (ii) The annuity is actuarially sound, and

   (iii) The annuity provides payments in equal amounts, with no deferred or balloon payments.

4. If an annuity is absent of such proof as outlined in this subparagraph (d), the purchase of the annuity will be considered a transfer for less than fair market value which is subject to a penalty. The burden is on the institutionalized individual, or his or her representative, to produce the necessary documentation.

(e) The issuer of the annuity must notify the State when there is a change in the disbursement of income or principal from the annuity.

(f) The application for assistance, including the application for recertification, must include for long-term care services the required disclosure under Section 1917(e)(1) and (2) of the Social Security Act (42 U.S.C. § 1396p(e)(1) and (2)) as provided in subparagraph (a) above. Failure to complete an application form that meets these requirements will not affect the individual's eligibility for Medicaid; however, the individual will not be eligible for coverage of long-term care services unless the appropriate form is completed and signed.

(g) If the annuity is not subject to penalty as transferred assets, it must still be evaluated as income or resources, including spousal income or resources, and in the post-eligibility calculation, as appropriate.

1. A revocable annuity can be canceled and the funds used to purchase the annuity can be refunded to the purchaser. If the owner or payee may be changed, the annuity is assignable and can be sold on the secondary market.

   (i) If an annuity meets one or both of the criteria of revocable or assignable, it is a countable resource. If the annuity is revocable, the resource value is the amount that the purchaser would receive if the annuity is canceled. If the annuity is assignable, the resource value is the amount the annuity can be sold for on the secondary market.

   (ii) If an annuity purchased by or for an individual who has applied for medical assistance with respect to nursing facility or other long-term care services is a countable resource, it is not treated as a presumptive transfer of assets for less than fair market value. However, assessing an annuity as a countable resource does not preclude an evaluation of the purchase of the annuity as a transfer of assets for less than fair market value if an assessment is warranted based on the circumstances. For example, if an assignable annuity is sold on the secondary market for less than its fair market value, a transfer of assets for less than fair market value may have occurred.

(h) The provisions of this paragraph (7) shall apply to all transactions occurring on or after February 8, 2006, including the purchase of an annuity and any other transaction that changes the course of payments to be made or the treatment of income and principal under an existing annuity, such as additions of principal, elective withdrawals, request

to change the distribution of the annuity, elections to annuitize the contract and other similar actions.

(i) Routine changes which occur, based on the terms of an annuity which existed prior to February 8, 2006, and which do not require a decision, election, or action to take effect are not considered a transaction. Routine changes would also include an address change or death or divorce of a remainder beneficiary and other similar circumstances.

1. For example, if an annuity purchased in June 2001 included terms which require distribution to begin five years from the date of purchase, and payouts consequently begin, as scheduled, in June 2006, this will not be considered a transaction since no action was required to initiate the change.

2. Changes which are beyond the control of the individual, such as changes in law, a change in the policies of the issuer, or a change in terms based on other factors, such as the issuer's economic conditions, are not considered transactions.

(8) Qualified Income Trust (QIT).

(a) ~~Effective July 1, 2005, i~~Individuals who are receiving or will receive nursing facility services or home and community based services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and whose income exceeds the Medicaid Income Cap (MIC) may establish an income trust, referred to as a Qualified Income Trust (QIT) or "Miller Trust". Funds placed in a QIT that meets the standards set forth in paragraph (8) are not treated as available resources or income for purposes of determining the individual's ~~Medicaid~~ TennCare eligibility.

(b) A QIT is a trust consisting only of the individual's pension income, Social Security Income, and other monthly income that is created for the purpose of establishing income eligibility for ~~Medicaid~~ TennCare coverage when an individual is or soon will be confined to a nursing facility, HCBS or ICF/MR waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program.

(c) An individual is eligible to establish a QIT if his or her income is above the level at which he or she would be financially eligible for nursing facility, HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, or ICF/MR care under Medicaid.

1. The amount of income that an applicant/recipient places in a QIT cannot be limited nor can it be counted when testing income against the Medicaid Income Cap (MIC). If the applicant/recipient's income that is not placed in a QIT is over the MIC, the individual is not financially eligible for nursing home Medicaid.

2. This Department of Human Services State Rule 1240-03-03-.03(8) shall apply to an income trust established on or after July 1, 2005 and with the undue hardship provision in Section 1613(e) of the Social Security Act. Hardship may be considered to exist when the institutionalized spouse and/or his/her spouse would have resources in excess of the resource limit, is otherwise eligible and for whom Medicaid ineligibility would result in loss of essential nursing care, which is not available.

(d) A QIT must meet the following criteria:

1. The trust must be irrevocable and cannot be modified or amended in whole or in part by the Grantor at any time. However, the Trustee or a court of competent jurisdiction shall have the right and jurisdiction to modify any provision of the trust to the extent necessary to maintain the eligibility of the Grantor for medical assistance.

2. Other than disbursements under Part 3 below, each month the Trustee may only make disbursements from the trust for:

   (i) A personal needs allowance up to the amount recognized under Tennessee Medicaid policies. As of January 1, 20~~05~~10, this amount is ~~Forty~~ Fifty Dollars ($~~40~~50) per month;

   (ii) Up to Twenty Dollars ($20) in necessary expenses for management of the trust (i.e., bank charges);

   (iii) A spousal income allocation in the amount permitted under Tennessee Medicaid policies;

   (iv) Expenses for health insurance premiums for health insurance coverage of the Grantor other than Medicaid; and

   (v) Expenses for qualifying medical or remedial care received by the Grantor, to the extent such care is recognized under Tennessee law as provided in Department of Human Services State Rule 1240-03-03-.04(2)(d) but not covered as medical assistance under the State's Medicaid program.

3. Each month the Trustee shall distribute the entire amount of income remaining in the trust after any disbursements made under Part 2 above to the State of Tennessee, Bureau of TennCare (or directly to the nursing facility or HCBS provider or Managed Care Organization (MCO) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, as directed by the Bureau of TennCare), up to the total amount of expenditures for medical assistance for the Grantor.

4. The sole beneficiaries of the trust are the Grantor for whose benefit the trust is established and the State of Tennessee (Bureau of TennCare). The trust terminates upon the death of the Grantor, or if the trust is no longer required to establish Medicaid eligibility in the State of Tennessee, if nursing facility or HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program is no longer medically necessary for the Grantor, or if the Grantor is no longer receiving such services.

5. The trust must provide that upon the death of the Grantor or termination of the trust, whichever occurs sooner, the State of Tennessee (Bureau of TennCare) shall receive all amounts remaining in the trust up to the total amount of medical assistance paid by the State on behalf of the individual.

6. Amounts remaining in the trust that are owed to the State must be paid to the Bureau of TennCare within three (3) months after the death of the individual or termination of the trust, whichever is sooner, along with an accounting of the disbursements from the trust. The Bureau of TennCare may grant an extension if a written request is submitted within two months of the termination of the trust.

(9) Assessment of Resources and Community Spouse Resource Allowance.

(a) Resources owned by either spouse, or by both spouses together, are considered equally available to both spouses at the beginning of a continuous period of institutionalization (i.e., 30 consecutive days in nursing care) for persons institutionalized after September 30, 1989. If an assessment of resources is requested by the institutionalized or community spouse or by either spouse's authorized representative, an assessment will be made within thirty (30) days of receipt of all relevant documentation from the requesting party(ies). If either spouse is dissatisfied with the Department's assessment of the community spouse's resource allowance at the point an application for Medicaid has been filed, either spouse has a right to a fair hearing with respect to the determination, which shall be held within thirty (30) days of the date a request for hearing is made.

(b) The community spouse resource allowance is equal to the greater of:

1. Effective ~~January~~ April 1, 200~~8~~9 one-half (1/2) of the total resources owned by both spouses not to be less than twenty-one thousand ~~eight~~ nine hundred ~~eighty~~ twelve dollars ($~~20,880~~21,912) nor greater than one hundred ~~four~~ nine thousand ~~four~~ five hundred sixty dollars ($~~104,400~~109,560) and adjusted annually per federal law;

2. The amount established after a fair hearing by the Department of Human Services; or

3. The amount transferred under a court order against the institutionalized spouse for the support of the community spouse, using Tennessee's Medicaid eligibility standards, regardless of any other state laws relating to community property or the division of marital property.

(c) The maximum amount of income of the institutionalized spouse must be allocated to the community spouse before increasing the resource allocation.

(d) Spouses must be legally married pursuant to the laws of the State of Tennessee; and

(e) The community spouse resource allowance determined by the assessment will be deducted from the value of all available resources owned by both spouses as of the first month for which assistance is requested. After the initial month of eligibility, no resources of the community spouse will be considered available to the institutionalized spouse.

(f) Allocation of Additional Resources to the Community Spouse.

1. Additional resources may be allocated to the community spouse through the administrative appeals process, in accordance with the criteria specified below, in order to make up any shortfall between the allocation of income as specified in 1240-03-03-.04 and either the standard maintenance amount (SMA) or the maximum monthly income allowance (MMIA), as deemed appropriate.

2. The amount of additional resources that are necessary to cover the shortfall in the SMA or MMIA shall be determined in reference to the purchase of a single premium annuity as follows:

(i) By calculating the shortfall in the SMA or MMIA and determining the amount of additional resources that must be invested in a single premium annuity in order to generate the income necessary to cover the shortfall.

(ii) The amount of resources needed to cover the shortfall shall be determined in reference to an annuity calculator as adopted by the Department in its TennCare / Medicaid Policy Manual.

3. The additional allocation of resources to the community spouse does not require the actual purchase of the single premium annuity that is used for purposes of calculating the amount of the additional resource allocation.

4. If a single premium annuity is actually purchased pursuant to these rules, the annuity must comply with all other relevant requirements of state and federal law.

5. The amount of additional resources that are necessary to cover the shortfall in the SMA or MMIA shall not be determined in reference to any investment which contemplates the return of the entire principal at maturity.

Authority: *T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(11) and (12), 71-5-102, 71-5-106, 71-5-111, and 71-5-121; 26 U.S.C. §§ 408 and 408A, 42 U.S.C. § 1382(a)(1)(B), 42 U.S.C. § 1382b, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396p, 42 U.S.C. § 1396p(c)(1)(A), (B), (C), (D), (E), (E)(iv), (F), (G), (H), (I) and (J), 42 U.S.C. § 1396p(c)(2)(D), 42 U.S.C. § 1396p(d)(4)(B), 42 U.S.C. § 1396p(d)(5) and 42 U.S.C. § 1396p(e)(1),(2),(3) and (4), 42 U.S.C. § 1396p(f)(1), (2), (3) and (4), 42 U.S.C. § 1396p(g), 42 U.S.C. § 1396r-5(b), (c), (d), (f) and (g), and 42 U.S.C. § 1396r-5(d)(6) and (e); 20 C.F.R. §§ 416.1205(c), 416.1212, 416.1220, 416.1222 and 416.1224; 42 C.F.R. § 435.601 and 435.602, 42 C.F.R. §§ 435.700, 435.725, 435.735, 435.831, 435.832, 435.840, 435.845, and 435.914 (b) and (c); 45 C.F.R. § 233.20; PL 97-248, PL 98-369 § 2611, PL 99-509 § 9401(a)(3), PL 101-239 Omnibus Reconciliation Act (OBRA) 1989 § 8014 and PL 103-66 OBRA 1993, Title XIII, Chapter 2, Subchapter B, Part II, § 13611, PL 104-193, and PL 109-171 §§ 6011, 6012, 6013, 6014, 6015, and 6016.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed July 27, 1978; effective October 30, 1978. Amendment filed June 9, 1981; effective October 5, 1981. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed February 28, 1983; effective March 30, 1983. Amendment filed January 30, 1985; effective March 1, 1985. Amendment filed February 26, 1985; effective March 28, 1985. Amendment filed March 31, 1986; effective April 30, 1986. Amendment filed April 15, 1986; effective July 14, 1986. Amendment filed August 20, 1986; effective October 4, 1986. Amendment filed May 8, 1987; effective August 29, 1987. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed February 26, 1988; effective May 29, 1988. Amendment filed March 7, 1988; effective June 29, 1988. Amendment filed April 8, 1988; effective July 27, 1988. Amendment filed August 9, 1989; effective September 23, 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. Amendment filed May 1, 2003; effective July 15, 2003. Public necessity rule filed September 30, 2005; effective through March 14, 2005. Amendment filed December 22, 2005, effective March 7, 2006. Public necessity rule filed June 1, 2007; expired November 13, 2007. Amendment filed August 30, 2007; effective November 13, 2007. Amendments filed April 22, 2008; effective July 6, 2008. Public necessity rule filed August 6, 2008; effective through January 18, 2009. Amendment filed October 31, 2008; effective January 14, 2009. Amendments filed August 5, 2009; effective November 3, 2009.*

1240-03-03-.04 INCOME LIMITATIONS FOR THE CATEGORICALLY NEEDY.

(1) Applicants and recipients for medical assistance as Categorically Needy in an AFDC-MO (Section 1931 of the Social Security Act [42 U.S.C. § 1396u-1]) coverage group are subject to the Centers for Medicare and Medicaid Services (CMS) approved earned income deduction. To calculate the deduction, select the Families First Consolidated Need Standard (CNS) for the appropriate Aid Group (AG) size and subtract ninety dollars ($90) plus thirty dollars ($30)

or one hundred and twenty dollars ($120) from the Families First CNS for the AG size. After deducting one hundred and twenty dollars ($120) from the CNS, subtract one-third (1/3) of the balance of the CNS. In addition, subtract the entire amount of the current Families First standard earned income disregard to arrive at the AFDC-MO earned income deduction.

Example: Current CNS for Aid Group size one (1) is $658.
Step 1: Subtract ninety ($90) plus thirty ($30) or $120 from $658. $658 minus $120 is $538.
Step 2: One third (1/3) of $538 is $179. $538 minus $179 is $359.
Step 3: $359 minus $250 (Families First standard earned income disregard) is $109. $109 is the AFDC-MO earned income disregard for a 1 person AG size.

Eligible AFDC-MO applicants and recipients with earned income receive the Families First standard earned income disregard plus the AFDC-MO earned income disregard. In the example above, the AFDC-MO individual would receive a combined earned income deduction of $359.00 ($250 Families First standard earned disregard and $109 AFDC-MO earned income disregard).

(2) Except as otherwise provided in paragraph (3) of this rule, SSI-related coverage groups are subject to income definitions and exclusions from income and policies as provided in 42 C.F.R. § 435.725, 42 C.F.R. 435.1005, 42 U.S.C. § 1382a and at 20 C.F.R. Part 416, Subpart K Income.

(a) Any aged, blind or disabled individual confined to long term nursing care in a facility ~~or in Home and Community Based Services (HCBS)~~ must be likely to be continuously confined for at least thirty (30) consecutive days, as evidenced by an approved NF Preadmission Evaluation eligibility segment which, when combined with the days already confined, total at least 30 days, prior to attaining Medicaid eligibility or if enrolled in a HCBS waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and likely to receive HCBS services for at least 30 consecutive days going forward, may have countable income equal to or less than 300% of the SSI/FBR beginning the month of admission.

(b) The otherwise eligible individual confined to a long-term care facility is required to assume some of his/her cost of care.

1. Personal Needs Allowance: ~~$40~~50 for an individual. The personal needs allowance for each person receiving Medicaid in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation is $50.

(i) The maximum personal needs allowance for persons participating in CHOICES Group 2 is 300% of the SSI Federal Benefit Rate.

(ii) The maximum personal needs allowance for persons participating in one of the State's Section 1915(c) HCBS waivers is as follows:

(I) The Statewide HCBS E/D Waiver: 200% of the SSI Federal Benefit Rate.

(II) The Statewide MR Waiver: 200% of the SSI Federal Benefit Rate.

(III) The Arlington MR Waiver: 200% of the SSI Federal Benefit Rate.

(IV) The Self-Determination MR Waiver: 300% of the SSI Federal Benefit Rate.

2. Effective ~~January~~ April 1, 200~~8~~9, spousal/dependent allocation not to exceed two thousand ~~six~~ seven hundred ~~ten~~ thirty-nine dollars ($~~2,610~~2,739) per family, and adjusted annually per federal law, which includes:

   (i) the spousal allocation using a standard maintenance amount (SMA) based upon one hundred fifty percent (150%) of the federal poverty level for two (2) persons for one (1) year divided by twelve (12) months, minus the community spouse's available countable income in addition to excess shelter expenses that exceed thirty percent (30%) of the SMA, in addition to

   (ii) The dependent allocation which equals the SMA minus each dependent's gross countable income divided by three. Department relatives include all individuals who can be or are claimed for Federal income tax purposes by either spouse; and

   (iii) The Medically Needy Income Standard (MNIS) will be used to determine the dependent allocation when there is no community spouse.

(c) Qualified Medicare Beneficiaries may be income eligible if such an individual's total income does not exceed one hundred percent (100%) of Federal Poverty Guidelines.

(d) The otherwise eligible individual confined to a long-term care facility is required to assume some of his/her cost of care.

The following deductions are made from the total income available for the cost of long-term nursing home care in the following order:

1. Personal needs allowance: $~~40~~50 for an individual.

2. Allocation to eligible dependent(s) at home reduced by the amount of the dependent's own income.

3. Monthly costs for health insurance premium(s) paid by the eligible individual.

4. Payments for medical or remedial care recognized under state law, but not encompassed within the State's Medicaid plan subject to the following criteria.

   Non-Covered Medical Expenses

   (i) Reserved for future use.

   (ii) Eyeglasses and necessary related services. Deductions can only be made for the following services and must be the lesser of the provider's usual and customary charges, billed charges, or the amounts indicated in the TennCare fee schedule.

   Examination and refraction
   Frame
   Lenses (bifocal)
   Lenses (single)

   (iii) Hearing aids and necessary related services. Deductions can only be made for the following services and must be the lesser of the provider's

usual and customary charges, billed charges, or the amounts indicated in the TennCare fee schedule.

Audiogram
Ear mold
Hearing aid
Batteries
Hearing aid orientation

(iv) Dental services.

(I) In addition to the deductions from the total income available for the cost of long-term nursing home care authorized by rules and regulations of the Department of Human Services, Division of Medical Services for an eligible individual confined to a long-term care facility, a deduction shall also be authorized and made from such total income available for the costs of routine and emergency dental services paid by the eligible individual.

(II) Deductions for such routine and emergency dental services, as defined by the Bureau of TennCare, shall only be made for those purposes and in such amounts as determined annually by the Bureau of TennCare's dental fee listing, whether such services are provided at a dental office, on-site at the long-term care facility, or through a mobile dental services provider that contracts with the long-term care facility.

(v) Specialized chairs such as electric wheelchairs. Deductions will be restricted to the lesser of the Medicare prevailing charges or the Medicaid established fee.

(vi) Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days when the recipient is away from the nursing facility are not allowable deductions. These charges are allowed only when the individual is in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). (TennCare allows a ten (10) day bed hold).

(vii) Charges incurred by the nursing facility for failure to timely submit or renew a previously submitted Pre-Admission Evaluation (PAE) are not allowable deductions.

5. Patient liability overcharges adjustment.

(e) Qualified Disabled Working Individual may be income eligible, if the individual income does not exceed 200% of the Federal Poverty Guidelines.

(f) Specified Low-Income Medicare Beneficiaries (SLMB) may be income eligible, if the individual's income does not exceed 120% of Federal Poverty Guidelines.

(g) Qualified Individuals 1 (QI-1) may be income eligible if the individual's income does not exceed one hundred thirty-five percent (135%) of Federal Poverty Guidelines.

(h) Reserved.

(3) Post-eligibility treatment of income for individuals participating in ~~the State's~~ Home and Community Based ~~Project~~ Services (HCBS) offered either through CHOICES Program or through a Section 1915(c) of the Social Security Act HCBS waiver program will be determined as follows:

(a) Total gross income will consist of the eligible individual's own income after deduction of the personal needs allowance (maintenance need based on the SSI/FBR for an individual living in the home) has been made for the participating individual and spouse, if applicable.

(b) An allocation will be made to the community spouse and/or dependents as indicated in Paragraph (2)(b)2. herein.

(c) Deductions cited in 1240-03-03-.04(2)(d) will be made from the total gross income with the exception of the personal needs allowance.

***Authority**: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, 71-5-111, 71-5-140, and 71-5-147; 42 U.S.C. § 1302, 42 U.S.C. § 1382a, 42 U.S.C. § 1382b, 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(50) and (51), and 1396a(1), (q) and (r); 42 U.S.C. § 1396d(p) and (s), 42 U.S.C. § 1396r-5, 42 U.S.C. §§ 1396r-5(b) and 5(d)(3)(B) and (C); 42 C.F.R. §§ 435.700, 435.725, 435.726, 435.735, and 435.845; PL 99-272, PL 100-360 § 301, and PL 100-360 § 303. **Administrative History:** Repeal and new rule filed June 14, 1976; effective July 14, 1976. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed June 27, 1985; effective July 27, 1985. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed August 5, 1988; effective November 29, 1988. Amendment filed November 30, 1988; effective January 14, 1989. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed May 1, 1991; effective June 15, 1991. Amendment filed April 23, 1997; effective July 7, 1997. Amendment filed October 26, 2001; effective January 9, 2002. Amendment filed May 1, 2003; effective July 15, 2003. Public necessity rule filed July 2, 2007; expires December 14, 2007. Amendment 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.*