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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Tennessee Department of Finance and Administration
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Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	ADA
Address:	Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
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Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Legislative Plaza, Room 16 301 6th Avenue North		
City:	Nashville, TN		
Zip:	37243		
Hearing Date :	06/27/16		
Hearing Time:	10:00 a.m.	X CST/CDT ___ EST/EDT	

Additional Hearing Information:

Revision Type (check all that apply):

___ Amendment
X New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	**Chapter Title**
1200-13-20	TennCare Technical and Financial Eligibility
Rule Number	**Rule Title**
1200-13-20-.01	Scope and Authority
1200-13-20-.02	Definitions and Acronyms
1200-13-20-.03	Delineation of Roles and Responsibilities
1200-13-20-.04	Technical Eligibility Requirements
1200-13-20-.05	General Application Requirements
1200-13-20-.06	Financial Eligibility Determinations
1200-13-20-.07	Family and Child Eligibility Groups
1200-13-20-.08	Aged, Blind or Disabled Categories
1200-13-20-.09	Redetermination and Termination

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Rules of the Bureau of TennCare/Medicaid 1200-13, are amended by adding a new chapter 20 titled TennCare Technical and Financial Eligibility, as follows:

Rules
of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-20
TennCare Technical and Financial Eligibility

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1200-13-20-.01 Scope and Authority.

(1) This chapter governs the processes for determining financial and categorical eligibility for the TennCare and CoverKids programs. This chapter preempts any other TennCare and CoverKids rules pertaining to eligibility determination to the extent that they are in conflict.

(2) The Tennessee Medical Assistance Act of 1968 and Executive Order Number 23, dated October 19, 1999, designate the Tennessee Department of Finance and Administration as the Single State Agency for purposes of administering Title XIX of the Social Security Act (Medicaid).

(3) The CoverKids Act of 2006 authorizes the Tennessee Department of Finance and Administration to establish and administer a program to provide health care coverage to uninsured children under Title XXI of the Social Security Act (State Children's Health Insurance Program – CHIP).

(4) Titles XIX and XXI of the Social Security Act, TennCare Medicaid Section 1115 Demonstration Waiver as

may be amended, extended, or renewed in the future, and 42 CFR Parts 431 and 435 require the designated State agency to provide for eligibility determinations for applicants for assistance and services provided through the programs.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.02 Definitions and Acronyms.

(1) AAAD – Area Agency for Aging and Disability

(2) ABD – Aged, Blind or Disabled

(3) Access to Health Insurance (TennCare). See definition in Rule 1200-13-13-.01. Access to health insurance through the Federally Facilitated Marketplace shall not constitute "access to insurance" for purposes of eligibility for TennCare.

(4) Active SSI Recipients. Persons who have been found eligible to receive SSI benefits by the SSA.

(5) AFDC – Aid to Families with Dependent Children

(6) Aged. An individual age 65 or older.

(7) Aid to Families With Dependent Children (AFDC). The name of the cash assistance program for families and children prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in July 1996.

(8) Annuities. Contracts or agreements that, in exchange for a lump sum payment or series of payments, provide for the payment of income at regular intervals, e.g., monthly, quarterly, annually, etc. Annuities establish a source of income for a future period and are often used in retirement planning.

(9) Applicant. An individual who is seeking an eligibility determination for himself through an application submission or a transfer from another agency or insurance affordability program. For purposes of this chapter, applicant also includes an individual who is seeking an eligibility determination for himself through an application for Medicare Savings Programs (MSP).

(10) Application. The single, streamlined form developed for use for all insurance affordability programs, as required by 42 CFR § 435.907(b), or the application form used in determining Medicaid eligibility for Long Term Services and Supports, Hospice Care, and Medicare Savings Programs.

(11) Application File Date.

(a) For applications for LTSS and MSPs, or EMS applications filed directly with the State: the date a valid application form is received by HCFA or its designee.

(b) For LIS applications from SSA: the date provided by SSA.

(c) For applications through the FFM: the date provided by the FFM.

(12) APTC – Advanced Premium Tax Credit

(13) APTC/CSR – Advanced Premium Tax Credit/Cost Sharing Reductions

(14) BCCP – Breast and Cervical Cancer Prevention

(15) Blind. An individual who is determined to be blind by the SSA.

(16) Breast and Cervical Cancer Prevention (BCCP). The Medicaid eligibility category defined at Section 1902(aa) of the Social Security Act (42 U.S.C. § 1396a(aa)). This eligibility category covers individuals who

have been found to have breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program, who are under age 65, do not otherwise have creditable coverage (including current enrollment in Medicaid), as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§ 2701(c) of the PHS Act (42 U.S.C. § 300gg(c)), are not otherwise eligible for Medicaid or receiving TennCare Standard, and who are currently undergoing treatment for breast or cervical cancer.

(17) Bureau of TennCare (Bureau). See definition in Rule 1200-13-13-.01.

(18) Caretaker Relative. A relative of a dependent child by blood, adoption, or marriage with whom the child lives, assumes primary responsibility for the child's care, and is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or

(b) The spouse of such caretaker relative, even after the marriage is terminated by death or divorce.

(19) CCRC – Continuing Care Retirement Community

(20) CHIP. The Children's Health Insurance Program established by Title XXI of the Social Security Act.

(21) CHOICES. TennCare CHOICES in Long-Term Care, as defined in TennCare Rule 1200-13-01-.02.

(22) CMS (Centers for Medicare & Medicaid Services). See definition in Rule 1200-13-13-.01.

(23) Community Spouse. The legal spouse of an institutionalized individual. A community spouse may not reside in a medical institution or nursing facility.

(24) Comprehensive Aggregate Cap Waiver. See definition in Tennessee's 1915(c) Home and Community Based Services Waiver.

(25) Completed Application. An application that meets the following criteria:

(a) All required fields have been completed;

(b) Is signed and dated by the applicant, the applicant's parent or guardian, an individual acting on behalf of the applicant, or an authorized representative;

(c) Includes all supporting documentation required by the Bureau to determine TennCare or CoverKids eligibility, including technical and financial requirements as set out in this chapter;

(d) If the application is for the TennCare Standard Medically Eligible category, it includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in this chapter.

(26) Continuous Eligibility. Enrollment in TennCare or CoverKids with no lapse in coverage.

(27) Core Medicaid Population. Individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: active SSI recipients who are receiving benefits as determined by the SSA; individuals eligible for emergency services as an undocumented or ineligible alien; individuals in a presumptive eligibility period; and children in DCS custody, including DCS children who meet the criteria for immediate eligibility and those receiving adoption assistance payments.

(28) CoverKids. The name given to the Children's Health Insurance Program (CHIP) in Tennessee under T.C.A. § 71-3-1101.

(29) CoverKids Pregnant Women/Unborn Children. Provides maternity care coverage for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage, who meet the CoverKids eligibility requirements.

(30) CSIMA – Community Spouse Income Maintenance Allowance

(31) CSRMA – Community Spouse Resource Maintenance Allowance

(32) DAC – Disabled Adult Child

(33) DCS – Department of Children's Services

(34) Deemed Newborn. An individual eligible in a Medicaid category authorized by Section 1902(e)(4) of the Social Security Act (42 U.S.C. § 1396a(e)(4)) and 42 CFR § 435.117.

(35) DIMA – Dependent Income Maintenance Allowance

(36) Disabled. An individual who has been determined to be disabled by the SSA.

(37) Disabled Adult Child (DAC). The Medicaid eligibility category defined in Section 1634(c) of the Social Security Act (42 U.S.C. § 1383c(c)).

(38) Effective Date. The first date of eligibility for purposes of health care services coverage and payment.

(39) Eligible. A person who has been determined to meet the eligibility criteria of TennCare Medicaid, TennCare Standard, or CoverKids.

(40) Enrollee. An individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the U. S. Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act or in the CoverKids program. (42 U.S.C. § 1315 or 42 U.S.C. § 1396n). For purposes of this chapter, enrollee also includes individuals eligible for and enrolled in the Medicare Savings Programs (MSPs).

(41) Enrollment. The process by which a TennCare or CoverKids eligible individual becomes enrolled in TennCare or CoverKids.

(42) Exchange. A governmental agency or non-profit entity that meets the applicable Federal standards and makes QHPs, including TennCare and CoverKids, available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a Small Business Health Options Program (SHOP) serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by the Department of Health and Human Services (HHS).

(43) Extended Medicaid. Medicaid eligibility authorized for enrollees who lose Child MAGI, Pregnancy MAGI, or Caretaker Relative MAGI eligibility due to increased receipt of spousal support, whose household income prior to losing eligibility was at or below the current Caretaker Relative MAGI income standard for 3 of the 6 months preceding the month of the increase in income.

(44) Families First (FF). Tennessee's Temporary Assistance for Needy Families (TANF) program was created by the PRWORA in 1996. TANF became effective in July 1996 and replaced what was then commonly known as the AFDC program.

(45) Federal Data Services Hub. An electronic service established by the HHS to facilitate sharing of data and other information between federal agencies, State agencies, and other entities involved in administering Insurance Affordability Programs.

(46) Federal Financial Participation (FFP). See definition in Rule 1200-13-13-.01.

(47) Federal Poverty Level (FPL). The poverty level established annually by HHS.

(48) Federally Facilitated Marketplace (FFM). See "Exchange."

(49) FEMA – Federal Emergency Management Agency

(50) FF – Families First

(51) FFM – Federally Facilitated Marketplace

(52) FFP – Federal Financial Participation

(53) Financially Responsible Relatives (FRR). Principle of financial responsibility between spouses and of parents to their children which is used in determining household composition, income counting and resource counting for certain Medicaid categories.

(54) Former Foster Care Children Under 26. The Medicaid eligibility category defined at Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(A)(i)(IX)).

(55) FPL – Federal Poverty Level

(56) FRR – Financially Responsible Relatives

(57) Full-Time Student. A student is defined as a child under age 21, unless otherwise specified in this chapter, attending primary or secondary school, college, university, or a course of vocational or technical training.

(a) A child retains his or her student status during official school vacations and breaks if the requirement prior to the vacation or break was met, and the student plans to return.

(b) A child who is receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher meets student requirements.

(c) An elementary school is defined as a State-approved educational institution comprised of grade kindergarten through eighth grade.

(d) Participation in apprenticeships, correspondence courses, other courses of home study and rehabilitation programs other than academic, institutional, vocational or technical training do not qualify a child as a student.

(e) A full-time student for college or university is an individual who is enrolled in at least 12 credit or semester hours per semester. A part-time student is an individual who in enrolled in at least 6 but less than 12 credit or semester hours per semester. (T.C.A. §§ 49-4-902(18) and (29)).

(58) Group Health Insurance. An employee benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50-or-more participants criteria do not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.

(59) HCBS – Home and Community Based Services

(60) HCFA – Health Care Finance and Administration

(61) Health Care Finance and Administration (HCFA). The State agency that oversees most of the health care related divisions within the Tennessee Department of Finance and Administration, including the Bureau of TennCare, the Office of eHealth, the Cover Tennessee Programs and the Strategic Planning and Innovation Group.

(62) Health Insurance (for CoverKids).

(a) Health insurance including, but not limited to, basic medical coverage (hospitalization plans), major medical insurance, comprehensive medical insurance, short-term medical policies, mini-medical

plans, and high-deductible plans with health savings accounts. For purposes of eligibility, other coverage includes Medicare, TennCare, TRICARE, employer-sponsored coverage.

(b) Health insurance shall not include the following:

1. CoverTN;

2. AccessTN;

3. Catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of $3,000 (or the maximum allowed deductible for a health savings account plan);

4. Dental-only plans;

5. Vision-only plans;

6. Benefits provided by the U.S. Department of Veterans Affairs or the Indian Health Service.

7. Coverage under the State of Tennessee's Children's Special Services program; or

8. Medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (Pub. L. No. 99-272, 29 U.S.C. §§ 1161, et seq.) and which the individual declined, or to T.C.A. §§ 56-7-2312, et seq., and which the individual declined.

(c) Consistent with 42 U.S.C. § 1397jj(b)(2)(B) and 42 CFR. §§ 457.301 and 457.310(c)(1)(ii), health insurance shall not include State-administered or other medical coverage offered by means of a family member's employment with a local education agency (LEA) if the LEA does not make more than a nominal contribution (as defined at 42 CFR § 457.310(c)(1)(ii)) to the premium for the dependent, who is applying (or re-applying) for coverage through CoverKids.

(63) Health Insurance (for TennCare).

(a) Health insurance, for purposes of determining eligibility under these rules, shall mean:

1. Any hospital or medical expense-incurred policy;

2. Medicare;

3. TRICARE;

4. COBRA;

5. Medicaid;

6. State health high-risk pool;

7. Nonprofit health care service plan contract;

8. Health maintenance organization subscriber contracts;

9. Group Health Insurance;

10. Coverage available to an individual through membership in a professional organization or a school;

11. Coverage under a policy covering one person or all members of a family under a single policy where the contract exists solely between the individual and the insurance company;

12. Any of the above types of policies for which:

    (i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;

    (ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;

    (iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition.

13. Any of the types of policies listed in (12) will be considered Health Insurance even if one or more of the following circumstances exists:

    (i) The policy contains fewer benefits than TennCare;

    (ii) The policy costs more than TennCare; or

    (iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.

(b) Health insurance, for purposes of determining eligibility under these rules, shall not mean:

1. Short term coverage;

2. Accident coverage;

3. Fixed indemnity insurance;

4. Long-term care insurance;

5. Disability income contracts;

6. Limited benefits policies as defined elsewhere in these rules;

7. Credit insurance;

8. School-sponsored sports-related injury coverage;

9. Coverage issued as a supplement to liability insurance;

10. Automobile medical insurance;

11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

12. A medical care program of the Indian Health Services (IHS) or a tribal organization;

13. Benefits received through the U.S. Department of Veterans Affairs; or

14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White CARE Act.

(64) Health Insurance Marketplace a.k.a. "Marketplace", "Exchange" or "Federally Facilitated Marketplace". See "Exchange."

(65) Home and Community Based Services (HCBS). See Rule 1200-13-01-.02.

(66) Household Size. The number of persons counted as members of an individual's household for purposes of determining eligibility for TennCare or CoverKids.

(67) ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities.

(68) Immediate Eligibility (for DCS children only). An arrangement whereby children in the custody of the State who are presumed to be TennCare-eligible may gain TennCare eligibility while their applications are being processed.

(69) Inactive SSI Enrollee. Individuals whose SSI cash benefits have been terminated by SSA and who remain eligible for TennCare until they have been reviewed for coverage in other eligibility categories. Inactive SSI enrollees are not eligible for CHOICES.

(70) Incarcerated. The state of being confined in a local, State, or federal prison, jail, youth development center, or other penal or correctional facility, including the state of being on furlough from such facility.

(71) Individual Health Insurance. Health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.

(72) Infants and Children Under Age 19. The Medicaid eligibility categories defined at Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX); and 1396u-1(b) and (d)).

(73) Insurance Affordability Program. A program that is one of the following:

(a) TennCare.

(b) CoverKids.

(c) APTC/CSR for participation in a QHP available through the FFM.

(74) Institutional Spouse. An institutionalized individual who is the legal spouse of a community spouse.

(75) Institutionalized Individual(s). The Medicaid eligibility category defined at Section 1902(a)(10)(A)(ii)(V) of the Social Security Act. (42 U.S.C. § 1396(a)(10)(A)(ii)(V)).

(76) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An institution described at 42 CFR Part 483, Subpart I.

(77) IRA – Individual Retirement Account

(78) ITEM D. The term used in Tennessee to refer to the methodology for deducting incurred expenses for necessary medical or remedial care for institutionalized persons in the post-eligibility phase of income defined at 42 CFR §§ 435.725(c)(4), 435.726(c)(4) and 435.832.

(79) 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.

(80) Limited Benefits Policy. A policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).

(81) Long-Term Care. See "Long-Term Services and Supports" (LTSS).

(82) Long-Term Services and Supports (LTSS) Program. See definition in Rule 1200-13-01-.02.

(83) LTSS – Long-Term Services and Supports

(84) MAGI – Modified Adjusted Gross Income

(85) Marketplace. See "Exchange."

(86) Medicaid. See definition in Rule 1200-13-13-.01.

(87) Medicaid Income Cap (MIC). 300% of the SSI Federal Benefit Rate.

(88) Medicaid "Rollover" Enrollee. A TennCare Medicaid enrollee under the age of 19 who no longer meets eligibility requirements for Medicaid and who is afforded an opportunity to enroll in TennCare Standard in accordance with the provisions of these rules.

(89) Medically Needy. The Medicaid eligibility category described at Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(C)).

(90) Medically Needy Income Standard (MNIS). See definition at 42 CFR § 435.811.

(91) Medicare. The program administered through the SSA pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to some individuals that have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

(92) Medicare Buy-In. The process by which TennCare "buys" Medicare beneficiaries into the Medicare program. The Medicare buy-in consists of paying for some or all of a beneficiary's Medicare premiums, deductibles, and coinsurance.

(93) Medicare Savings Program (MSP). One of the programs under which low-income Medicare beneficiaries can get assistance from Medicaid for paying for some or all of their Medicare premiums, deductibles, and coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, the Qualifying Individual (QI1) program and the Qualified Disabled and Working Individual (QDWI) program.

(94) Member. See "Enrollee."

(95) MIC – Medicaid Income Cap

(96) Miller Trust. See "Qualified Income Trust."

(97) MNIS – Medically Needy Income Standard

(98) Modified Adjusted Gross Income (MAGI). See definition at 42 CFR § 435.603(e).

(99) MSP – Medicare Savings Program

(100) Newborn Presumptive. The Medicaid eligibility category described at 42 CFR § 435.1102.

(101) Nursing Facility (NF). See definition in Rule 1200-13-.01-.02.

(102) PACE – Program of All-Inclusive Care for the Elderly

(103) PACE Carryover Group. See definition in Rule 1200-13-01-.02.

(104) PASS – Plan to Achieve Self Support

(105) Patient Liability. See definition in Rule 1200-13-01-.02.

(106) Payment for Emergency Medical Services. Eligibility authorized by Section 1903(v) of the Social Security

Act (42 U.S.C. § 1396b(v)).

(107) Personal Needs Allowance. See definition in Rule 1200-13-01-.02.

(108) Pickle Passalong. The eligibility category defined at 42 CFR § 435.135.

(109) Pregnant Women. For purposes of the Medicaid program, the Medicaid eligibility category defined at Sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Social Security Act, (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX)); and 1396u-1(b) and (d)); and 42 CFR 435.116.

(110) Presumptive Eligibility for Individuals with Breast or Cervical Cancer. Individuals presumed to be eligible for coverage under the Medicaid category authorized by Section 1902(aa) of the Social Security Act (42 U.S.C. § 1396a(aa)) based on a determination by the Tennessee Department of Health or other qualified entity.

(111) Presumptive Eligibility for Pregnant Women. Women presumed to be eligible for coverage in the category defined at Sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), (IX); and 1931(b) and (d) of the Social Security Act, (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX); and 1396u-1(b) and (d)); and in 42 CFR 435.1103 by the Tennessee Department of Health or other qualified entity.

(112) Program of All-Inclusive Care for the Elderly (PACE). See definition in Rule 1200-13-01-.02.

(113) QDWI – Qualified Disabled and Working Individual

(114) QHP – Qualified Health Plan

(115) QI1 – Qualifying Individual

(116) QIT – Qualified Income Trust

(117) QMB – Qualified Medicare Beneficiary

(118) Qualified Disabled and Working Individual (QDWI). An individual who is under age sixty-five (65), has lost free Medicare Part A coverage due to substantial gainful activity, has a disabling impairment, has the option to purchase Medicare Part A for an indefinite period of time, and for whom Medicaid pays the Medicare Part A premium, 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 and is not otherwise eligible for Medicaid. Eligibility is authorized by Sections 1905(p)(3)(A)(i);, 1905(s); and 1902(a)(10)(E)(ii) of the Social Security Act, (42 U.S.C. §§ 1396d(p)(3)(A)(i) and (s); and 1396a(a)(10)(E)(ii)).

(119) Qualified Health Plan (QHP). See definition at 42 USC 18021.

(120) Qualified Income Trust (QIT). The trust defined at 42 U.S.C. § 1396p(d)(4)(B).

(121) 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 Rule 0780-01-61 as:

(a) A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

(b) 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.

(122) Qualified Medicare Beneficiary (QMB). An individual who is entitled to and receives Medicare Part A and for whom Medicaid pays the Medicare Part A and Part B premium, coinsurance, and deductible for Medicare-covered services and whose income is not more than one hundred percent (100%) of the federal poverty level. Eligibility is authorized by Sections 1905(p) and 1902(a)(10)(E)(i) of the Social Security Act, (42 U.S.C. §§ 1396d(p) and 1396a(a)(10)(E)(i)).

(123) Qualifying Individual 1 (QI1). An individual who is entitled to and receives Medicare Part A, for whom Medicaid pays Medicare Part B premiums on a first-come, first-served basis, and who has income at least one hundred and twenty percent (120%) of the federal poverty level but not more than one hundred and thirty-five percent (135%) of the federal poverty level. Individuals are not enrolled in TennCare Medicaid or TennCare Standard. Eligibility is authorized by Section 1902(a)(10)(E)(iv) of the Social Security Act, (42 U.S.C. § 1396a(a)(10)(E)(iv)) and 42 U.S.C. § 1396u-3.

(124) Qualifying Medical Condition. A medical condition which is included among a list of conditions established by the Bureau and which will render a qualified uninsured applicant medically eligible.

(125) Redetermination. The process by which TennCare evaluates the ongoing eligibility status of TennCare Medicaid enrollees who are considered a part of the Core Medicaid Population, as well as TennCare Standard and CoverKids enrollees. This is a periodic process that is conducted at specified intervals. The process is conducted in accordance with TennCare's, or its designee's, policies and procedures. This is also referred to as "Renewal."

(126) Renewal. See "Redetermination."

(127) Responsible Party(ies). The following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, and guardians; as defined at T.C.A. § 71-5-103(12).

(128) Single State Agency (CoverKids and TennCare). The Department of Finance and Administration.

(129) SLMB – Specified Low Income Medicare Beneficiary

(130) 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 at least one hundred percent (100%) of the federal poverty level but not more than one hundred twenty percent (120%) of the federal poverty level. Eligibility is authorized by Sections 1905(p)(3)(A)(ii) and 1902(a)(10)(E)(iii) of the Social Security Act, (42 U.S.C. §§ 1396d(p)(3)(A)(ii) and 1396a(a)(10)(E)(iii)).

(131) 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.

(132) SSA – Social Security Administration

(133) SSI – Supplemental Security Income

(134) SSI – Related Groups. Individuals who have been found eligible in one of the following categories:

(a) Disabled Adult Children (DAC).

(b) Pickle Passalong.

(c) Widow/Widowers.

(135) Standard Child Medically Eligible. An uninsured child under age nineteen (19) who is losing eligibility for Medicaid or currently enrolled in TennCare Standard, whose household income exceeds two hundred and eleven percent (211%) of the federal poverty level, who does not have access to health insurance, and who has been determined medically eligible in accordance with these rules.

(136) Standard Child Uninsured. The TennCare Demonstration category defined as including persons in the following groups:

(a) Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, or are currently enrolled in TennCare Standard, who have household incomes at or below two hundred and eleven percent (211%) of the federal poverty level, and who do not have access to health insurance; or

(b) Uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below two hundred percent (200%) of the federal poverty level, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. At such time as a person loses eligibility in this category, he will not be able to re-enroll in it.

(137) 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.).

(138) TANF – Temporary Assistance for Needy Families

(139) Temporary Assistance for Needy Families (TANF). A program created by the PRWORA in 1996. TANF became effective in July 1996 and replaced what was then commonly known as the AFDC program. The name given to Tennessee's TANF program is Families First.

(140) TennCare. The program administered by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee.

(141) TennCare CHOICES in Long-Term Services and Supports. The program described in Rule 1200-13-01-.05. CHOICES is a benefit package available to TennCare enrollees who are eligible in the Institutional eligibility category or who are active SSI enrollees and who meet the requirements of the program set out in chapter 1200-13-01.

(142) TennCare Medicaid. That part of the TennCare program which covers persons eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following persons are eligible for TennCare Medicaid:

(a) Tennessee residents determined to be eligible for Medicaid in accordance with this chapter.

(b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.

(c) A Tennessee resident who is an uninsured individual, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, and has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.

(d) Tennessee residents determined eligible for SSI benefits by the SSA are automatically enrolled in TennCare Medicaid.

(143) TennCare Standard. That part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in this chapter.

(144) Tennessee Health Connection (TNHC). Working title of the entity contracted with TennCare to provide service center functionality, including a call center and document intake.

(145) Termination. See definition in Rule 1200-13-13-.01. Also means the discontinuance of an enrollee's coverage under the CoverKids program.

(146) Title IV-E. The section of the Social Security Act under which grants are made to States for implementation of foster care and adoption assistance programs. Eligibility is authorized by Section 1902(a)(10)(A)(i)(I) of the Social Security Act, 42 CFR 435.115, and 42 CFR 435.145.

(147) TNHC – Tennessee Health Connection

(148) Transitional Medicaid. Medicaid authorized for enrollees who lose Child MAGI, Pregnancy MAGI, or Caretaker Relative MAGI eligibility due to increased earnings and whose household income prior to losing eligibility was at or below the current Caretaker Relative MAGI income standard for 3 of the 6 months immediately preceding the month of the increase in income.

(149) Uninsured. See definition in Rule 1200-13-13-.01.

(150) Valid Application. Either the single application form for all insurance affordability programs or the application form for LTSS or MSPs. It must include contact information and be signed by the applicant or his representative.

(151) WIA – Workforce Investment Act

(152) Widow/Widower. The eligibility category defined at 42 CFR § 435.138.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.03 Delineation of Roles and Responsibilities.

(1) Agencies' Roles and Responsibilities.

(a) The Bureau of TennCare (Bureau) is responsible for determining eligibility for both TennCare and CoverKids and for conducting appeals of eligibility-related decisions, unless otherwise agreed to by the Single State Agency and CMS. The Bureau is also responsible for coordinating the eligibility process for TennCare and CoverKids with the eligibility process for APTC/CSR in the FFM, in accordance with 42 CFR §§ 435.1200 and 1205, unless otherwise agreed to by the Single State Agency and CMS.

(b) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for some TennCare Medicaid and TennCare Standard applicants who have open SNAP cases, as well as to redetermine, at regular intervals, whether eligibility should be continued for some enrollees. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.

(c) With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.

(d) The Tennessee Department of Children's Services is responsible for determining eligibility for Medicaid foster care and adoption assistance categories.

(e) The Tennessee Department of Health (DOH) is responsible for conducting presumptive eligibility determinations for pregnant women and individuals in the BCCP category.

(f) The SSA is responsible for determining eligibility for receipt of benefits from the SSI program. Individuals receiving SSI payments in Tennessee determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid.

(g) The FFM is responsible for making TennCare Medicaid and CoverKids eligibility determinations for categories using MAGI income methodologies based on an agreement between the State and the FFM. The FFM is also responsible for assessing applicants who may be eligible for other Medicaid eligibility categories and transmitting those applicants to the State for full review.

(h) The Bureau is responsible for notifying applicants of recovery for LTSS expenditures. Section 1917 of the Social Security Act (42 U.S.C. § 1396p), 42 CFR §§ 433.36 and 435.700, et seq., and T.C.A. § 71-5-116.

(2) Enrollee Roles and Responsibilities.

(a) Each TennCare enrollee and each CoverKids enrollee is responsible for reporting to HCFA, any material change in the information affecting eligibility given by the applicant/enrollee to the Bureau of TennCare or to the FFM. This information includes, but is not limited to, changes in address, income, household size, employment, or access to insurance. When submitting changes to the State, the applicant/enrollee shall mail, fax, or present in person, any required documentation of any such change to TennCare. When submitting changes to the FFM the applicant/enrollee shall mail or electronically upload any required documentation of any such change to the FFM. General contact information such as phone number and address changes may be updated by phone call to TNHC. Changes must be reported within 10 days of the occurrence.

(b) All verifications requested must be furnished within 10 days of the notice requesting additional information unless otherwise specified by federal law.

(c) Each TennCare enrollee and each CoverKids enrollee is responsible for reporting to his provider that he is a TennCare or CoverKids enrollee.

(d) By accepting medical assistance through the TennCare program, every enrollee is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Persons applying as Caretaker Relatives under Medicaid (see Rule 1200-13-20-.07) must cooperate in establishing the paternity of dependent children and obtaining medical support. Failure to cooperate in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating TennCare eligibility.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.04 Technical Eligibility Requirements.

(1) State Residency. Persons enrolled in TennCare must meet the requirements for State residency established in 42 CFR § 435.403. Persons applying for CoverKids must meet these requirements as well as those specified at 42 CFR § 457.320(d).

(a) Temporary absence. Individual may be "temporarily absent" from Tennessee but still considered a resident of the State for purposes of TennCare and CoverKids eligibility. An individual who wishes to be considered temporarily absent from the State for continued eligibility purposes must provide the Bureau of TennCare with an anticipated date of return. The Bureau will assess the continuation of an individual's temporary absence status 10 days after the individual's anticipated date of return.

A temporary absence from the State will not preclude continued eligibility under the following circumstances:

1. The absence is for a specific purpose such as a temporary work assignment, visit, hospitalization, participation in an educational or rehabilitation program not available in Tennessee; or

2. The absence is for a child receiving specialized treatment out of State; and

3. The individual indicates his intent to return to Tennessee once the purpose for his absence is accomplished.

(b) Students.

1. Individuals who are dependents of a Tennessee resident and who attend school out of State will be considered Tennessee residents.

2. Individuals aged 18 to 22 who are considered to be dependents of a non-Tennessee resident and who attend school full time in State will not be considered Tennessee residents.

(2) Citizenship. Persons enrolled in TennCare or CoverKids must meet the requirements for citizenship or qualified non-citizen status established in 42 CFR § 435.406.

(a) Qualified aliens who entered the United States on or after August 22, 1996, are barred from receiving TennCare Medicaid or CoverKids benefits for five years from the date of entering the U.S. before potential eligibility for TennCare or CoverKids unless they meet the exceptions to the five (5) year bar as outlined in 8 U.S.C. § 1613(b).

(b) For CoverKids, unborn children are presumed to be U.S. citizens, regardless of the citizenship or immigration status of the mother.

(3) Social Security Number (SSN).

(a) Persons enrolled in TennCare or CoverKids must meet the requirements of 42 CFR § 435.910.

(b) Unborn children enrolled in CoverKids Pregnant Women/Unborn Children are not required to have an SSN.

(c) SSNs are not required for members of households who are not applying for TennCare or CoverKids coverage.

(4) Incarceration. Persons who are incarcerated are eligible for TennCare in a suspended status pursuant to T.C.A. § 71-5-106(r), as long as all eligibility criteria are met. Persons in a suspended status will be eligible for TennCare payments for medical institution stays longer than 24 hours only. All other medical payments while in the suspended status are not subject to TennCare reimbursement. The suspended status will be removed once the State receives notice that the enrollee is no longer incarcerated. See also 42 CFR § 435.1010.

(5) Residents of an Institution for Mental Disease (IMD). Persons who are residents of an IMD are not eligible for FFP, except for those who are age 65 or older and confined to an approved ward, or those who are under age 22 and receiving inpatient psychiatric services. Confinement in an IMD does satisfy and establish institutional status for individuals under 65 and those confined to unapproved wards who are subsequently admitted to a medical institution. See Section 1905 of the Social Security Act (42 U.S.C. § 1396d).

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.05 General Application Requirements.

(1) Right to apply.

(a) Any person wishing to do so shall have the opportunity to apply for TennCare Medicaid or CoverKids without delay.

(b) Information about the TennCare or CoverKids program administered by HCFA shall be provided to any person requesting it pursuant to 42 CFR § 435.905.

(c) Applications may be filed by the applicant, his authorized representative or someone acting responsibly for him. See 42 CFR § 435.923.

(d) Proof of eligibility is not required of a person prior to filing an application.

(e) The right to file an application shall not be denied to any person even if it is apparent that eligibility for TennCare or CoverKids does not exist.

(2) Rights and responsibilities.

(a) By applying for TennCare or CoverKids, an applicant grants permission and authorizes release of information to TennCare, or its designee, to investigate any and all information provided, or any

information not provided if it could affect eligibility, to determine TennCare or CoverKids eligibility; and if approved, what cost sharing, if any, may be required of the applicant. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other State where income is earned;

3. The Tennessee Department of Labor and Workforce Development, and other Employment Security offices within any State where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or,

6. Any other governmental agency or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare or CoverKids Program. The Federal Data Services Hub, or "electronic service" referred to in 42 CFR § 435.949, is an example of such an information source.

(b) It is a felony offense, pursuant to T.C.A. § 71-5-2601, to apply for TennCare coverage under false means or to help anyone obtain TennCare under false means.

(c) By applying for TennCare Medicaid, an applicant agrees to provide information to the Bureau, or its designee, about any third party coverage in which the applicant is enrolled.

(3) Submitting an application.

(a) TennCare will accept applications in accordance with 42 CFR § 435.907 and, for CoverKids applicants, 42 CFR § 457.330, or as otherwise agreed to by the Single State Agency and CMS.

(b) An application can be filed by one of the following individuals, as applicable:

1. Adult applicants or an adult who is in the applicant's household as defined in 42 CFR § 435.603(f);

2. An adult who is in the applicant's family, as defined in the Internal Revenue Code § 36B(d)(1);

3. Applicants who are over age 14 but under age 18 who are emancipated or are considered sufficiently mature to make their own health care decisions;

4. A parent who has primary custody of a minor child;

5. Either parent of a minor child when custody is equally divided between legal parents;

6. The legal guardian or conservator;

7. An authorized representative, as defined in 42 CFR § 435.923; or

8. If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.

(c) Applications received from Tennessee residents living out of State.

1. Applications filed for Tennessee residents who are temporarily out of State may be accepted.

2. The application of someone who is hospitalized in another State and planning to return to Tennessee when discharged may be processed in the usual manner.

(d) Out of State applicants.

1. Applications received from persons residing in another State and not intending to reside in Tennessee will be denied.

2. Persons who are in Tennessee for a temporary purpose, such as a visit, who intend to return to their home out of State are not eligible for TennCare or CoverKids.

3. Applicants must always be given the right to submit an application if they wish to do so and receive a decision on their application.

(4) Assistance with submitting an application. HCFA is required to provide assistance to any individual seeking help with the application or redetermination process in person by Certified Application Counselors (CACs), over the phone, and online in a manner that is accessible to individuals with disabilities and those who have limited English proficiency. Assistance includes, but is not limited to, the following:

(a) Help with form completion;

(b) Help securing a representative, if needed, and/or allowing someone of the applicant's choice to assist with the application and renewal process; and

(c) Help in obtaining necessary information from third parties.

(5) Applications may be filed in any of the following ways:

(a) By mail.

1. LTSS and MSP: Paper LTSS/MSP applications must be submitted to TNHC. The Application File Date for LTSS/MSP applications mailed to TNHC will be the date the application is received at TNHC.

2. All categories of TennCare and CoverKids except MSPs:

(i) Mail paper applications to the FFM. The Application File Date will be the date provided by the FFM.

(ii) Mail an application to TNHC. If an FFM application is mailed to TNHC, the State will forward the application to the FFM to be processed. The Application File Date will be the date provided by the FFM, or as otherwise agreed to by the Single State Agency and CMS.

(b) By phone.

1. LTSS and MSP: Call TNHC or the local AAAD (or MCO if current TennCare enrollee). TNHC will provide a paper application that must be submitted by mail or fax. The Application File Date for LTSS/MSP applications will be the date the application is received at TNHC.

2. All other categories of TennCare and CoverKids except MSPs: Call the FFM. The Application File Date will be the date provided by the FFM.

3. Newborn applicants may call TNHC to either be added as a Deemed Newborn or apply for Newborn Presumptive coverage. The Application File Date for a Newborn Presumptive will be the date of determination by the qualified entity.

(c) By fax.

1. LTSS and MSP or EMS applicants: Fax an application to TNHC. The Application File Date for LTSS/MSP/EMS applications faxed to TNHC will be the date the application is received at TNHC.

2. All other categories of TennCare and CoverKids: Fax application to TNHC. If an FFM application is faxed to TNHC, the State will forward the application to the FFM to be processed. The Application File Date will be the date provided by the FFM, or as otherwise agreed to by the Single State Agency and CMS.

(d) By online submission of the application through the FFM. The application is then transferred to HCFA. The Application File Date will be the date provided by the FFM.

(e) In person at any DHS county office.

1. LTSS and MSP: Submit a paper LTSS/MSP application at the local DHS office. The Application File Date for LTSS/MSP applications submitted to DHS will be the date of receipt at DHS.

2. All categories of TennCare and CoverKids other than MSPs: Complete an online application by using a kiosk at a DHS office or by telephone. Applications filed with the FFM, using the FFM Web site, call center or paper application, are processed by the FFM. Once processed, the federal government transmits the applicant's information to HCFA through an electronic file.

(6) Processing time. Eligibility will be timely determined in accordance with 42 CFR § 435.912, or as otherwise agreed to by the Single State Agency and CMS.

(7) Disposition.

(a) Eligibility is determined based on information contained on the completed application form as well as information secured during the application process.

(b) All applications will be subject to one (1) of the following actions:

1. Approval. When all eligibility factors are met, the application is approved.

2. Denial. When one or more eligibility factor(s) is not met, the application is denied.

(i) Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

(ii) Applicants who do not respond to requests for verifications by the State in a timely manner will be denied for failure to respond to such requests.

(iii) Applicants who do not provide sufficient information in response to requests for verifications by the State will be denied.

(c) Withdrawal. When an applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.06 Financial Eligibility Determinations.

(1) Modified Adjusted Gross Income (MAGI) Financial Eligibility Determinations.

(a) All applicants for TennCare or CoverKids will have their income calculated for eligibility purposes in accordance with the MAGI-based requirements at 42 CFR § 435.603. The only exceptions are the Medicaid applicants at 42 CFR §§ 435.603(j)(1)-(6).

(b) In accordance with 42 CFR § 435.603(g)(1), there is no resource or asset test for individuals whose income eligibility is required to be determined using MAGI income requirements.

(c) There is no resource or asset test for pregnant women or children enrolled in CoverKids.

(d) In accordance with 42 CFR § 435.603(g)(2), there are no income or expense disregards for individuals whose eligibility is determined in accordance with MAGI requirements, with the exception of those described at 42 CFR §§ 435.603(d)(1) and (4).

(e) Household composition, for financial eligibility determination purposes, for TennCare Medicaid (Child, Pregnant Women and Caretaker Relative categories), TennCare Standard Children Uninsured, TennCare Standard Medically Eligible, and the CoverKids categories will be determined using the MAGI methodology in accordance with 42 CFR § 435.603(f). Household composition for all other categories will be determined in accordance with this chapter. MAGI household composition methodology is based on federal tax rules and the principles of tax dependency, however the MAGI rules apply to both applicants who expect to file taxes or be claimed as tax dependents, and to those applicants who do not file taxes or are not claimed as tax dependents. Each applicant has his own household size constructed under MAGI rules, and it is permissible for applicants who live in the same household to have different household sizes.

1. Tax Filers.

(i) For applicants who expect to file taxes, the household includes the tax filer and any dependents the tax filer expects to claim.

(ii) For applicants claimed as tax dependents, the household is the same as the tax filer claiming the tax dependent. Tax dependents may include individuals not otherwise eligible for TennCare Medicaid or CoverKids, and who are not applying for benefits. If a non-custodial parent claims a child as a dependent, the dependent child will be included in the non-custodial parent's household size.

(iii) For married couples who live together, each spouse will always be included in the other spouse's household, regardless of the couple's tax filing status.

(iv) There are three exceptions to the tax filer rule for applicants claimed as tax dependents. An applicant who meets any of the following is subject to the non-filer household composition rules:

(I) The tax filer is someone other than the applicant's spouse, or natural, adopted or step parent; or

(II) The applicant is under age 19, or 21 if a full-time student, and is claimed as a tax dependent by one parent, but his or her parents live together and do not file a joint tax return; or

(III) The applicant is under age 19, or 21 if a full-time student, and expects to be claimed as a tax dependent by a non-custodial parent.

2. Non-Filers. Applicants who do not file taxes are subject to the non-filer household composition rules. The non-filer household includes the applicant and if living with the applicant:

(i) The applicant's spouse;

(ii) The applicant's natural, adopted and step children under age 19, or 21 if a full-time student;

(iii) For applicants under age 19, or 21 if a full-time student, the applicant's natural, adopted or step parent; and

(iv) For applicants under age 19, or 21 if a full-time student, the applicant's natural, adoptive and step siblings who are under age 19, or 21 if a full-time student.

(f) The household size for a pregnant woman includes the number of children she is expected to deliver (the unborn child(ren)). The household size for other applicants in a pregnant woman's household does not include the unborn child(ren).

(2) AFDC-Related Financial Determinations.

(a) Coverage groups whose financial eligibility is determined in accordance with AFDC-based methodologies are:

1. Medically Needy Children; and

2. Qualified Medically Needy Pregnant Women.

(b) Income Determinations. Income for individuals described in this paragraph is calculated according to the AFDC cash assistance program's income definitions and policies (Tenn. Comp. R. & Regs. 1240-01-04-.12 and .14 - .19, and 45 CFR § 233.20). Unless otherwise specified below, these individuals are subject to the following income requirements:

1. Adoption Subsidies – Countable to the child if intended for general living expenses. Excluded if for reimbursement of child care while the adult responsible for the child is at work or seeking employment, for medical expenses, or from State adoption assistance programs or Title IV-E funds for special needs children.

2. Alimony Received – Countable.

3. Annuity Payments – If the underlying annuity is an excluded resource, the periodic payments are countable unearned income. If the underlying annuity is a countable resource, payments are excluded.

4. Assistance Payment from another State – Countable.

5. Bonuses – Countable.

6. Cancelled Debts – Excluded.

7. Capital Gains – Countable.

8. Cash Support – Countable, unless excluded as infrequent or irregular income.

9. Census Payments – Excluded.

10. Child Support Payments – Countable, both current payments and arrears.

11. Child/Spousal Support Transferred to IV-D Agency – Payments transferred by the household to DCS as assigned support are excluded.

12. Commissions – Countable.

13. CSIMA – Countable as unearned income only when the institutionalized individual is not in the community spouse's household.

14. Contractual Payments – Countable.

15. Death Benefits – Countable income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.

16. Deferred Wages – Countable when the income would have normally been received if the

wages are deferred at the employee's request. Countable when received if the wages are deferred by the employer.

17. DIMA – Countable as unearned income only when the institutionalized individual is not in the dependent's household.

18. Differential Payments – Countable.

19. Domestic Commercial Transportation Tickets – Excluded as long as tickets are not converted to cash.

20. Domestic Volunteer Service Act Payments – Excluded as income if payments are made for supporting services or reimbursements for out-of-pocket expenses.

21. Dwelling-related Assistance – Excluded if housing assistance is provided by HUD or FMHA.

22. Earned Income Tax Credits – Excluded.

23. In-Kind Income: Wages, Food, Shelter or other – Countable.

24. Earned In-Kind Food or Shelter – Countable.

25. Earned In-Kind Not Food or Shelter – Countable.

26. Earned In-Kind Wages – Countable.

27. Education Income that is Not Work Study – Includes: Pell Grant; SEOG Grant; National Direct Student Loan; Guaranteed Student Loan; State Student Initiative and any financial aid:

    (i) Excluded - if paid directly to the school and unavailable to the student.

    (ii) Countable - as unearned income: Any portion of the grant, scholarship or fellowship that is not used to pay tuition, fees, or other necessary education expenses.

28. FF/TANF Payments – Excluded.

29. Farmer Income – Countable.

30. Farmer/Fishing Income – Countable.

31. Gambling Prizes and Awards – Countable.

32. Gifts – Cash gifts are countable unless excluded as infrequent or irregular income. In-Kind gifts are countable, and the value is equal to the current market value.

33. Income Produced from Resources – Countable.

34. Inheritance Cash – Countable.

35. Interest Bearing Resources – Interest earned on a resource, dividends, royalties and other direct money payments is countable.

36. Interest on Burial Funds and Spaces – Excluded.

37. Irregular or Infrequent Income – Up to $30 of unearned or earned income received infrequently or irregularly per quarter is excluded.

38. Jury Duty Pay – Countable unless the income is turned over to an applicant's employer.

39. Low Income Home Energy Assistance Payments (LIHEAP) – Excluded.

40. Military Allotments – The Family Subsistence Supplemental Allowance (FSSA) and the Military Basic Allowance for Housing (BAH) are countable as unearned income.

41. Payments from FEMA – FEMA payments issued as a result of presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by States, local governments and disaster assistance organizations are also excluded. FEMA payments which are made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable.

42. Pensions – Countable.

43. PASS Payments – Excluded.

44. Protective Payee Payments – Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his or her own use is countable income to the protective payee. Even if the protective payee retains a fee for his or her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.

45. Railroad Retirement Payments – Countable.

46. Rehabilitation Payments – Net rehabilitation payments are countable as unearned income. Deduct allowable expenses from the gross rehabilitation payment.

47. Reimbursements – Reimbursement of expenses an employee incurs in the performance of his or her duties for items other than normal living expenses are excluded.

48. Rental or Lease Income – Countable as earned income when the individual is actively engaged in producing such income, or bears some responsibility in earning the income. Countable as unearned income when the individual is not actively engaged in producing the income, or bears no responsibility in earning the income. Count the amount of income remaining after expenses related to maintaining the property are applied.

49. Royalties and Honoraria – Countable.

50. Self Employment – Net earnings are countable.

51. Settlements and Restitutions – The following settlements and restitution payments are excluded as unearned income:

    (i) Filipino Veterans Compensation Fund Payments. Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

    (ii) Agent Orange Settlement Payments. Excluded as unearned income but counted when determining patient liability for institutionalized individuals;

    (iii) German Reparation Payments;

    (iv) Japanese-American and Aleutian Restitution Payments;

    (v) Alaska Native Claims Settlement Act exclusions;

    (vi) State funds paid to crime victims;

(vii) Payments made to individuals because of their status as victims of Nazi persecutions;

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida;

(ix) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act;

(x) Distribution of perpetual judgment funds to Indian tribes under the following:

(I) Indian Judgment Funds Distribution (P.L. 93-134)

(II) Black Feet and Gros Ventre Tribes (P.L. 92-254)

(III) Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

(IV) Tribes of groups under P.L. 93-134;

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

(VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.

52. Severance – Countable.

53. Sick/Disability Payments – Countable.

54. Social Security Payments – Countable.

55. Social Service Payments – Excluded.

56. Strike Benefits – Countable.

57. Supplemental Nutrition Assistance Program (SNAP) – The value of a SNAP benefit is excluded. The value of free or reduced food under WIC or the National School Lunch Act is also excluded.

58. SSI Payments – Excluded.

59. Temporary Disability Payments – Income is countable as unearned income to the extent it is not a reimbursement for specific costs and is paid directly to the applicant or any member of the applicant's household.

60. Tips – Any amount over $20 per month is countable.

61. Trusts – Money withdrawn from the body of a trust or interest and dividends accrued to the trust and paid to the individual is countable.

62. Unemployment Compensation – Countable.

63. U.S. Department of Veterans Affairs Payments – Educational benefits, VA Aid & Attendance, Augmented VA benefits and VA payments from Unusual Medical Expenses are excluded.

64. VISTA Payments – Countable.

65. Wages – Countable.

66. Workers' Compensation – Countable.

67. WIA Payments – Excluded.

68. Work Study Payments – Exclude college work study income up to the amount necessary to pay for tuition and mandatory fees. Income in excess of tuition and fee costs is countable earned income.

(c) Resource Requirements. Resources for individuals described in this paragraph are calculated according to the AFDC cash assistance program's resource definitions and policies (Tenn. Comp. R. & Regs. 1240-01-04-.05, .07, .09 – .10; 42 CFR §§ 435.840 and 435.845; and 45 CFR § 233.20). Individuals described in this paragraph are subject to the following resource requirements:

1. Annuities – Excluded as a resource if it meets the requirements of 42 U.S.C. § 1396p(c)(1)(G). If the annuity is an excluded resource, payments being received from the annuity may be countable unearned income. If the annuity is a countable resource, any payments being received from the annuity are excluded. The countable value is its fair market value.

2. Business or Self-Employment – Excluded as essential for the production of earned income. Such excluded resources may include:

   (i) Tools/equipment;

   (ii) Stock or raw materials;

   (iii) Personal property essential for income production;

   (iv) Real property;

   (v) Office equipment;

   (vi) Business loans for the purchase of capital assets;

   (vii) Inventory;

   (viii) Machinery and equipment;

   (ix) Business/commercial checking accounts; and

   (x) Life insurance.

3. Burial Contracts or Policies – Excluded. This does not include pre-paid or pre-need burial agreements.

4. Burial Plot – Exclude the value of burial plots and spaces for all household members.

5. Prepaid Burial Agreements or Burial Trusts – Exclude one burial agreement or burial trust with equity value of $1500 or less per family member.

6. Cash – Countable.

7. Certificate of Deposit (CD) – Countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining value.

8. Checking Account – Personal checking accounts are countable. Other checking accounts may be excluded if designated for burial needs, educational income, Individual Development Accounts, PASS, prorated as income, proceeds from the sale of a home, disaster or settlement funds and retroactive SSA payments.

9. Contract for Deed or Mortgage – The value of a contract for deed or mortgage may be a countable asset depending on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset:

   (i) When the individual is the lender for a contract for deed, the lender may sell or transfer the instrument to have immediate access to the unpaid principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. The value of the contract may be excluded from the countable resource if the individual can demonstrate that the contract cannot be sold without his realizing a net loss.

   (ii) If the individual is the borrower, the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.

10. Educational Income – All educational income is excluded as a resource, including Title IV, Bureau of Indian Affairs, Department of Veterans Affairs and work study for post-secondary education. The individual must be enrolled in school and attending classes to be considered a student. Grants, scholarships, fellowships and gifts other than those previously listed intended to pay for tuition, fees or education expenses are excluded as a resource.

11. Farm, Business or other Equipment – The equity value of non-self-employment income-producing real property, other than the homestead, is countable. If the property is used for self-employment, it is excluded as Business or Self-Employment.

12. Rental property - Countable if the individual who owns the property is not 'in the business of' renting property. Someone who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least 20 hours per week.

13. Home and Lot – The entire value of the home, whether on land or water, and lot and all adjoining land not separated by property owned by others and any related outbuildings are excluded in determining resource eligibility, as long as the home is the principal place of residence for the applicant/enrollee. Temporary absences from the home do not affect the home's exemption, as long as the individual intends to return home at a specified time.

14. Household Goods and Personal Effects – Excluded.

15. Individual Development Account (IDA) – Funds, including accrued interest, in the account are excluded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions to the account.

16. Income-Producing Resource – Countable if accessible to the individual.

17. Sick and Disability Insurance – Excluded.

18. Burial Insurance – Excluded.

19. Items of Unusual Value – Exclude up to $2,000 of all total personal items of unusual value. If the individual's equity value in one or more than one item of unusual value is greater than $2,000, the amount that exceeds $2,000 is countable towards the resource limit.

20. Life Estates:

   (i) Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title, subject to the following exceptions:

      (I) A life estate will be excluded as the home when the property meets the home exemption.

(II) A life estate will be excluded when ownership is necessary for the production of earned income. See Business and Self-Employment.

(III) The terms of the life estate contract prevent the holder from selling his or her interest in the property.

(ii) If the life estate is not excluded based on the criteria above, the entire value of the life estate is a countable asset. The life estate value is determined by multiplying the fair market value of the property by the percentage listed in the "Life Estate Interest Table" for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.

21. Life Insurance – Excluded.

22. Livestock – The value of livestock necessary for business or self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. Livestock that is used as non-business, income-producing property is countable.

23. Oil and Mineral Rights – May be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when the surface rights of the same property are countable (non-homestead, real property).

    (i) If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, then oil and mineral rights are also excluded.

    (ii) If oil or mineral rights are producing income to the individual, and he or she is not actively engaged in the production of income, the equity value of the rights is countable.

24. Personal – Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and/or his or her family.

25. Personal Consumption – Exclude as a resource the equity value of a non-business property used to produce goods or services essential to daily activities.

26. PASS – Income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.

27. Proceeds from the Sale of a Home – Excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within three (3) months of the date of receipt of the proceeds.

28. Promissory Note and other Loans – A promissory note or other loan given by the household is considered personal property and is countable, unless the note/loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his or her share in the note or loan. The equity value of the note/loan is countable.

29. Prorated as Income – Excluded.

30. Real Property – The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:

    (i) Property excluded as the homestead;

(ii) The inaccessible equity value of real property;

(iii) Equity value of income-producing property;

(iv) Real property necessary for the production of earned income (see Business or Self-Employment); and

(v) Real property excluded under a Conditional Assistance agreement between the individual and the State. The individual must make a bona fide effort to sell the property at its current market value, and repay the State for medical expenses covered by HCFA during the exclusion period with the proceeds of the sale. Exemption of the real property is not to exceed 9 months. Only one parcel of property may be excluded under a Conditional Assistance agreement per period of eligibility.

(I) Repayment of medical expenses covered by HCFA may not exceed the total of the net proceeds. Any proceeds remaining after repayment to the State are considered a resource.

(II) If the property remains unsold after 9 months, the property is considered inaccessible so long as bona fide efforts to sell the property continue.

31. Retirement Accounts and Pension Plans – Excluded up to $20,000. Money held in an IRA, 401(K), or Keogh in excess of $20,000 is countable, minus any penalty for early withdrawal.

32. Savings Account – Countable if it is characterized by personal use. If the current month's income has been deposited into the account, it must be excluded when determining the current value of the account. A savings account may be excluded if it is used for one of the following purposes:

(i) Burial funds;

(ii) Business or Self-Employment;

(iii) Educational Income;

(iv) Individual Development Account;

(v) PASS;

(vi) Proceeds from the Sale of a Home (subject to time limits);

(vii) Prorated as Income;

(viii) Settlement or Disaster Payment, if Excluded by Policy; and

(ix) SSI/SSA Retroactive Payment (subject to time limits).

33. Settlement or Disaster Payment – Payments or benefits provided under certain Federal statutes are excluded, if payments are not commingled with other funds. Excluded settlement and/or disaster payments include:

(i) Agent Orange Settlement Payments. Payments and interest are excluded as unearned income but counted when determining patient liability for institutionalized individuals;

(ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;

(iii) Distribution of perpetual judgment funds to Indian tribes under the following:

(I) Indian Judgment Funds Distribution (P.L. 93-134)

(II) Black Feet and Gros Ventre Tribes (P.L. 92-254)

(III) Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

(IV) Tribes of groups under P.L. 93-134;

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

(VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.

(iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;

(v) Filipino Veterans Compensation Fund Payments. Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

(vi) Japanese-American and Aleutian Restitution Payments (and interest from payments);

(vii) Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments);

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments);

(ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded);

(x) Revenues from the Alaska Native Fund paid under Section 21(a) of the Alaska Native Claims Settlement Act; and

(xi) State funds paid to crime victims.

34. SSI/SSA Retroactive Payments – Excluded for 9 months after the payment is received and countable after the 9 month exclusion period.

35. Stocks, Bonds and Mutual Funds – Countable if asset is held for personal use. Stocks, bonds or mutual funds held for purposes listed below are subject to different treatment:

(i) Burial;

(ii) Business or Self-Employment;

(iii) Educational Income;

(iv) Proceeds from the Sale of a Home;

(v) Prorated as Income; or

(vi) Settlement or Disaster Payment, if Excluded by Policy.

36. Tools of the trade – Excluded when essential for the production of earned income.

37. Trusts – Countable or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, plus other factors.

38. Vehicles – Exclude up to $4,600 of the equity value of one vehicle in the applicant's household. The equity value of any other vehicle is countable, unless the vehicle can be excluded based on its use. The equity value of recreational vehicles (boats, snowmobiles, jet skis, ATVs and aircraft) is a countable resource.

(d) Disregards and Expenses Allowed. For purposes of determining the income of individuals described in this paragraph, the following expenses will be disregarded from their income:

1. Child Support Disregard – Disregard $50 per household if a child living in the home receives child support payments (current only) and the family receives TANF benefits.

2. Earned Income Disregard – Disregard $90 from each household member's total earned income.

3. Payments made on Behalf of Dependents within the Home – Disregard up to $175 per month of day care expenses per dependent age 2 or older. Disregard up to $200 per month of day care expenses per dependent under age 2.

4. Student Income – Disregard the earnings of a child who is a full-time student or part-time student and not employed full time.

(e) Household composition for TennCare Medicaid Medically Needy categories is based on the principle of FRR.

1. The following individuals must be included in the applicant's household for TennCare Medicaid Medically Needy Child, if living with the applicant:

   (i) The applicant;

   (ii) The applicant's spouse;

   (iii) The applicant's children under age 21;

   (iv) For applicants who are under age 21, the applicant's natural or adoptive parents; and

   (v) The applicant's siblings who are under age 21(including unborn children).

2. The TennCare Medicaid Medically Needy child applicant's parent(s) are not included if the applicant is an emancipated minor.

3. A step parent living in the home with a child applicant for TennCare Medicaid Medically Needy is not included in the child's household.

4. The following individuals must be included in the TennCare Medicaid Medically Needy Qualified Pregnant Woman applicant's household, if living with the applicant:

   (i) The pregnant woman applicant;

   (ii) The applicant's unborn child(ren);

   (iii) The applicant's spouse; and

   (iv) The applicant's children under age 21.

5. Parents of a pregnant woman applying for TennCare Medicaid Medically Needy Qualified Pregnant Woman coverage are not included in the applicant's household.

(f) Spend down.

1. Applicants must produce proof of relevant medical expenses in order to "spend down" monthly income to the TennCare Medically Needy Income Standard (MNIS) to be eligible in a Medically Needy category. If income is below the MNIS, spend down will not be necessary. Applicants may reduce available monthly income with countable expense, as listed below, in order to qualify for eligibility in the Medically Needy categories. The income limits for the Medically Needy category are published in the State Plan.

2. Countable Expenses. The following rules apply to the expenses that may be used to meet spend down:

   (i) Countable expenses incurred during the month of application, whether paid or unpaid.

   (ii) Countable expenses paid during the month of application, regardless of when such expenses were incurred.

   (iii) Countable expenses incurred during the three calendar months prior to the month of application, whether paid or unpaid.

      (I) Expenses paid during the three calendar months prior to the month of application will not be counted unless such expenses were also incurred during those three calendar months.

      (II) Any expenses incurred before the three calendar months prior to the month of application will not be counted unless payment is made on those expenses during the month of application, in which case only the amount paid during the month of application is counted.

      (III) When a Medically Needy enrollee has been eligible for 12 months, he will be expected to meet spend down again as described in this section, except verified expenses that are documented in the enrollee's Medicaid record can be carried over to the next year as long as the individual remains continuously eligible, the expenses remain unpaid, and the bills are not written off by the provider. Only the portions of expenses that were not previously used to meet spend down can be carried over to the next eligibility determination. If an enrollee loses eligibility at any point, the carryover of unpaid medical expenses ends and the enrollee must meet spend down as if he were a new applicant.

   (iv) All medical expenses are considered incurred the date the service is provided with the following exception: Medical expenses related to maternity care (e.g., global fee) are considered incurred the month the physician presents a bill once services have begun (i.e., initial examination by the physician at a minimum).

   (v) If spend down is not met by the medical bills incurred as of the date of application submission or as of the date of submission of a renewal application during redetermination, the daily countable medical expenses incurred during the application month will be added until spend down liability is reached.

3. Incurred or paid expenses for the following individuals may be considered countable expenses for purposes of determining Medically Needy financial eligibility:

   (i) The applicant;

   (ii) Members of the applicant's household;

   (iii) The applicants FRRs or anyone for whom the applicant is financially responsible; and

(iv) Individuals not living in the applicant's home or eligible for inclusion if the applicant's household member or an applicant's FRR is legally obligated to pay the applicant's medical expenses.

4. Countable expenses are those for which the individual is still liable and that are:

(i) For medical or remedial care, including costs for over the counter medications and costs incurred for medical insurance premiums, co-payments and deductibles. Health insurance premiums may be deducted as a spend down expense only when payment is due, even if paid in another month;

(ii) Verifiable and for which the individual provides substantiation;

(iii) Incurred by eligible individuals and are the legal responsibility of a household member and not subject to payment in full or part by a third party;

(iv) Recognized under State law but not covered under the State's TennCare Medicaid plan or waiver (continuously eligible individuals); or

(v) Covered under TennCare Medicaid but incurred during the spend down period (new applicants).

5. The following list includes but is not limited to the types of medical expenses that are considered Countable Medical Expenses for the Medically Needy categories:

(i) Acupuncture services.

(ii) Bed hold at a Long Term Care Facility (Medicaid rate).

(iii) Dental expenses.

(iv) Doctor's fees – includes fees from services rendered by practitioners and others providing medical services, physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, and Christian Science providers.

(v) Drugs prescribed by a physician (prior to TennCare eligibility) – includes charges for medicines and drugs prescribed by a doctor incurred prior to establishing TennCare Medicaid eligibility and which remained unpaid or paid in the month under consideration (i.e., Spend Down month).

(vi) Guide dogs – Guide dogs for the blind or deaf and the costs of their maintenance.

(vii) Hospital charges.

(viii) Medical care charges included in tuition costs – Charges for medical care included in the tuition fee of a college or private school which is paid on a monthly basis, provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.

(ix) Nursing home costs.

(x) Nursing services – Nursing services include nursing care in a client's home, if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder and ordered by a physician. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as the preparation of meals and the performance of housework, is not deductible.

(xi) Organ transplant expenses.

(xii) Prosthetic devises – Artificial teeth, limbs, hearing aids and component parts, eyeglasses and crutches.

(xiii) Psychiatric care – Psychiatric care primarily for alleviating a mental illness or defect; the cost of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care.

(xiv) Special education for handicapped – Special school for mentally or physically handicapped individuals if for the alleviation of handicap. The costs of meals and lodging, if supplied by the institution, and/or ordinary education furnished incidental to the special services are medical expenses.

(xv) Substance abuse treatment – Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment.

(xvi) Transportation for medical/remedial purposes – Transportation essential to medical care, e.g., bus, taxi, train, or plane fares, and 47 cents for each mile that the client's car is used for medical purposes, in addition to parking fees and tolls.

(xvii) Over the counter (non-prescription) medicine – $10 per month is deducted for these expenses without verification, using only the applicant's statement. All of these expenses must be verified if the amount is more than $10 per month.

6. The following are types of medical expenses that are not considered Countable Medical Expenses for the Medically Needy categories:

(i) Expenses that have been written off as uncollectible or have been forgiven by the provider.

(ii) Expenses that are covered by the State's TennCare Medicaid plan and are incurred during a period of eligibility:

(I) Costs incurred during a period of TennCare eligibility due to co-pays or services not covered such as dental, hearing and eye care for adults are allowable as a medical expense.

(II) Bills incurred during TennCare eligibility which are subject to TennCare reimbursement are not considered outstanding for subsequent spend down periods even if not paid by TennCare.

(3) ABD Financial Determinations.

(a) Coverage groups whose financial eligibility is determined based on SSI financial methodology are:

1. Members of SSI-Related Groups.

2. MSP Applicants.

3. Individuals applying for coverage of LTSS, under the Institutional Medicaid category.

(b) Income Determinations. Income countable for purposes of individuals described in this paragraph is defined at 20 CFR §§ 416.1100, et seq., and as set forth below. Unless otherwise specified below, these individuals are subject to the following income requirements:

1. Adoption Subsidies – Countable to the child if intended for general living expenses. Excluded if for reimbursement of child care while the adult responsible for the child is at work or seeking employment, or for medical expenses.

2. Alimony – Countable.

3. Annuity Payments – If the underlying annuity is an excluded resource, the periodic payments are countable unearned income. If the underlying annuity is a countable resource, payments are excluded.

4. Assistance Payment from another State – Countable.

5. Bonuses – Countable.

6. Care and Contribution in Exchange for a Transferred Asset – Countable.

7. Canceled Debts – Excluded.

8. Capital Gains – Countable.

9. Cash Support – Countable, unless excluded as irregular or infrequent income.

10. Child Support Arrearage – Countable.

11. Child Support Payments – Countable to the child(ren) the payments are intended to support. Exclude one-third (1/3) of the child support payment to or for an eligible child. The one-third exclusion does not apply to ineligible children.

12. Commissions – Countable.

13. CSIMA – Countable as unearned income only when the institutionalized individual is not in the community spouse's household. If the applicant is a deemed member of the institutionalized individual's household, the CSIMA is excluded.

14. Contractual Payments – Excluded.

15. Death Benefits – Countable income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.

16. DIMA – Countable as unearned income only when the institutionalized individual is not in the dependent's household. If the applicant is a deemed member of the institutionalized individual's household, the DIMA is excluded.

17. Differential Payments – Countable.

18. Domestic Volunteer Service Act Payments – Excluded if received through the following programs: Title II Retired and Senior Volunteer Program, and Foster Grandparent Program; Title III Service Corps of Retired Executives, Senior Companion Program, and Active Corps of Executives.

19. Earned Income Tax Credits – Excluded.

20. Earned In-Kind Food or Shelter – Countable.

21. Earned In-Kind Not Food or Shelter – Excluded.

22. Earned In-Kind Wages – Countable.

23. Education Income that is Not Work Study – Excluded.

24. Farmer/Fishing Income – Countable.

25. Gambling Prizes and Awards – Countable.

26. General Assistance Payments – Countable.

27. Gifts – Countable.

28. Income Not Pursued - Countable.

29. Income Produced from Resources – Income generated by a resource that is excluded is countable unearned income. Income generated by a resource that is countable is excluded as income.

30. Inheritance Cash – Countable.

31. Interest Bearing Resources – Interest earned on a countable resource is excluded as unearned income. Interest earned on an excluded resource is countable as income.

32. Irregular or Infrequent Income – Exclude up to $60 per calendar quarter of unearned income when it is received infrequently or irregularly. Exclude up to $30 per calendar quarter of earned income when it is received infrequently or irregularly.

33. Jury Duty Pay – Countable unless the income is turned over to an applicant's employer.

34. Long Term Care Insurance Payments – Countable if the payment is not assigned to the nursing home or lead HCBS agency.

35. Military Allotments – The Family Subsistence Supplemental Allowance (FSSA) and the Military Basic Allowance for Housing (BAH) are counted as unearned income.

36. Older Americans Act Payments – Countable.

37. Payments from FEMA – FEMA payments issued as a result of a presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by States, local governments and disaster assistance organizations are also excluded. FEMA payments which are made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable.

38. Pensions – Countable.

39. PASS Payments – Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his or her own use is countable income to the protective payee. Even if the protective payee retains a fee for his or her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.

40. Rental or Lease Income – Countable as earned income when the individual is in the business of renting or leasing property, i.e., self-employment. Countable as unearned income when the individual is not in the business of renting or leasing property. Count the amount of income remaining after expenses related to maintaining the property are applied.

41. Royalties and Honoraria – Countable.

42. Self-Employment – Net earnings are countable.

43. Settlements or Disaster Payments – The following settlements and disaster payments are excluded as unearned income:

(i) Agent Orange Settlement Payments. Payments and interest are excluded as unearned income but counted when determining patient liability for institutionalized individuals;

(ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;

(iii) Distribution of perpetual judgment funds to Indian tribes under the following:

(I) Indian Judgment Funds Distribution (P.L. 93-134)

(II) Black Feet and Gros Ventre Tribes (P.L. 92-254)

(III) Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

(IV) Tribes of groups under P.L. 93-134;

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

(VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.

(iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;

(v) Filipino Veterans Compensation Fund Payments. Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

(vi) Japanese-American and Aleutian Restitution Payments (and interest from payments);

(vii) Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments);

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments);

(ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded);

(x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and

(xi) State funds paid to crime victims.

44. Severance – Countable.

45. Sheltered Workshop Payments – Excluded.

46. Sick/Disability Payments – Countable.

47. Social Security Payments – Countable.

48. Social Service Payments – Excluded.

49. SSI – Excluded.

50. Temporary Disability Insurance – Income is countable as unearned income to the extent it is

not a reimbursement for specific costs and is paid directly to the household.

51. Tips – Any amount over $20 per month is countable.

52. Trusts – Dividends, interest, rents and other income generated by a trust fund, unless otherwise excluded, that can be paid to the beneficiary or to a third party on the beneficiary's behalf are countable income to the beneficiary for the period the fund is intended to cover, beginning the month the funds become available, regardless of whether the income is actually paid out to the beneficiary. When funds are withdrawn irregularly, the payments are countable in the month received.

    (i) Monies withdrawn from the principal of an accessible (countable) trust fund are excluded as income to the beneficiary, because an accessible trust fund is a countable resource. Money cannot be considered income and a resource in the same month.

    (ii) Monies disbursed from the principal of an inaccessible trust fund are counted as income because an inaccessible trust fund is an excluded resource.

    (iii) Monies received by the trustee of a trust and used for the care and maintenance of a third party beneficiary (adult or child) are excluded as income for the trustee.

53. Unearned In-Kind Income or In-Kind Support and Maintenance – Unearned In-Kind income in the form of food and/or shelter may be countable or excluded and is subject to certain rules that determine the countable or excluded value.

54. Unearned In-Kind Income, Not Food or Shelter – Excluded.

55. Unemployment Compensation – Countable.

56. U.S. Department of Veterans Affairs Payments:

    (i) Additional Child Allotment – Excluded.

    (ii) Compensation – Countable.

    (iii) Death Benefit – Countable as unearned income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.

    (iv) Dependency and Indemnity Compensation– Countable.

    (v) Pension – Veteran's benefits other than Aid and Attendance (A&A) are countable income. Homebound allowances are countable income. Any part of a veteran's pension that is attributable to A&A is excluded as income, but is treated as third party liability available to help meet the veteran's medical expenses. A&A will be contributed to the cost of care in the nursing home.

    (vi) If an institutionalized veteran receives the $90 reduced, improved pension, exclude the $90 from countable income and the cost of care calculation.

57. VISTA Payments – Excluded.

58. Wages – Countable.

59. Worker's Compensation – Excluded.

60. WIA Payments – Excluded.

61. Work Study Payments – Excluded.

(c) Resource Determinations. Resources countable for purposes of individuals described in this paragraph are defined at 20 CFR §§ 416.1201, et seq. Unless otherwise specified below, individuals described in this paragraph are subject to the following resource requirements:

1. Annuities.

(i) Annuities are countable resources when:

(I) The annuity is owned by the individual receiving or applying for TennCare Medicaid or an ABD eligible spouse but the annuity payments are made to someone else;

(II) The individual does not own 100% of the annuity (or the individual and his or her spouse do not own 100% of the annuity);

(III) The annuity is owned by an ABD ineligible spouse or a community spouse;

(IV) The annuity is owned by a deemed parent and it is not an employment related annuity; or

(V) The annuity does not meet any of the conditions described in subpart (iii) items (I)-(VI) below.

(ii) If an annuity meeting any of the conditions in subpart (i) is found to be legally inaccessible, it must be reviewed under the transfer of assets policy for individuals applying for long term services and supports.

(iii) Annuities owned by the individual or an ABD-eligible spouse are excluded resources if the annuity meets all of the following conditions:

(I) The annuity is irrevocable;

(II) The annuity is non-assignable;

(III) The annuity is annuitized;

(IV) The annuity is actuarially sound;

(V) The payment contract requires periodic payments of equal amounts;

(VI) Periodic payments are provided to the annuitant: and

(VII) The individual owns 100% of the annuity, or the individual and his or her ABD eligible spouse together own 100% of the annuity.

2. Business or Self Employment – Excluded as essential for the production of earned income. Resources may include:

(i) Tools/equipment;

(ii) Stock or raw materials;

(iii) Personal property essential for income production;

(iv) Real property;

(v) Office equipment;

(vi) Business loans for the purchase of capital assets;

(vii) Inventory;

(viii) Machinery and equipment;

(ix) Business/commercial checking accounts; and

(x) Life insurance.

3. Burial Funds.

(i) Burial funds which are not commingled are excluded resources when:

(I) The funds are used to purchase a life insurance policy which is then irrevocably assigned to a funeral provider. Either the ownership of the policy or proceeds may be assigned to the funeral provider. The purpose of the assignment is to fund a burial contract.

(II) The funds are invested in an irrevocable pre-paid or pre-need burial contract established by a funeral provider and the contract meets the following conditions:

I. Both the individual and the funeral home representative have signed the document;

II. An itemized list of the services provided under the contract is provided;

III. The total dollar amount of the agreement is specified;

IV. The individual was neither a minor nor legally declared incompetent when the agreement was signed; and

V. The agreement specifies in writing that the money is not refundable under any circumstances.

(III) The funds are invested in a burial trust established by the individual, and the total funds in the trust, including interest payments, do not exceed $6,000 per individual. Transport costs which cause the trust value to exceed $6,000 are excluded.

(ii) Burial funds are countable resources when:

(I) The funds are used to purchase a life insurance policy and a revocable assignment of the policy or proceeds is made to a funeral provider.

(II) The funds are invested in a revocable pre-paid or pre-need burial contract established by a funeral provider.

(III) Countable burial funds are eligible to be excluded as part of the individual's burial reserve.

(iii) Burial Reserve – An individual is allowed to set aside $1,500 in resources to cover expenses connected to his or her burial, cremation or other funeral arrangements. Funds allowed to be excluded as part of the burial reserve include revocable, countable burial funds. These funds must not be commingled with other resources, and must be set aside for burial expenses. The $1,500 maximum amount of the burial reserve is first reduced by:

(I) Life insurance, if the total value of all life insurance owned by the individual is $1,500 or less; and

(II) Funds in an irrevocable burial agreement or contract.

4. Burial Plots – Exclude the value of one burial space for each family member, e.g. spouse, child, parent, sibling, whether living in the home or not. Burial plots and spaces include a gravesite, crypt, mausoleum, niche or other repository for bodily remains, vaults, headstones, markers, plaques, containers and arrangement for opening and closing the gravesite.

5. Cash – Countable.

6. Certificates of Deposit (CD) – Countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining net value.

7. Checking Accounts – Personal checking accounts are countable. Some checking accounts that may be excluded include those designated for burial needs, educational income, Individual Development Accounts, PASS, prorated as income, proceeds from the sale of a home, disaster or settlement funds if excluded by policy, and retroactive SSA payments.

8. CCRC Deposit or Fee – The value of an entrance fee paid to a CCRC is a countable resource when it meets the following conditions:

   (i) The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;

   (ii) The entrance fee or its remaining portion is refundable when the individual dies or terminates the contract and leaves the CCRC; and

   (iii) The entrance fee does not confer any ownership interest in the community.

9. Contracts for Deed or Mortgage – The value of a contract for deed or mortgage may be a countable asset dependent on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset.

   (i) When the individual is the lender for a contract for deed, the lender may sell or transfer the instrument to have immediate access to the unpaid principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. The value of the contract may be excluded from the countable resources if the individual can demonstrate that the contract cannot be sold without his realizing a net loss.

   (ii) If the individual is the borrower the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.

10. Educational Income.

   (i) Educational income received under Title IV, Bureau of Indian Affairs, or Department of Veterans Affairs programs is excluded as a resource.

   (ii) Grants other than Title IV or Bureau of Indian Affairs grants, scholarships, fellowships and gifts intended to pay for tuition, fees or educational expenses are excluded for 9 months beginning the month after the funds are received. The individual must be enrolled in school and attending classes to be considered a student.

11. Farm, Business, Other Equipment – The equity value of non-self-employment income-producing real property, other than the homestead, is a countable resource. Exclude up to six thousand dollars ($6,000) in equity and count only the amount that exceeds the limit, if the net income totals at least six percent (6%) of the equity value. If the property is used for self-employment, it is excluded as Business or Self-Employment.

12. Rental property is countable if the individual who owns the property is not in the business of' renting property. Someone who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least 20 hours per week.

13. Homestead Exclusion - The entire value of the home, whether on land or water, all adjoining land not separated by property owned by others and any related outbuildings are excluded in determining resource eligibility as long as:

    (i) The home is the principal place of residence for the client and/or his spouse and/or dependent relatives; and

    (ii) If the individual resides in a long-term care facility, his intent to return to the home is established.

    (iii) For an institutionalized individual, the home is excluded if the above are true and the individual's equity interest does not exceed $552,000, with one exception: the home equity limit does not apply to an institutionalized individual if the spouse of the individual, the individual's child under age 21, or a blind or permanently and totally disabled child is residing in the home. An institutionalized individual whose home exceeds the $552,000 limit and who does not have a spouse, a child under age 21 or a disabled or blind child living in the home, is not eligible for payment of long term services and supports, unless it is determined undue hardship exists.

    (iv) An individual must have lived in the home for it to be considered his or her home or principal place of residence.

    (v) The value of the home and surrounding land will not be counted as a resource during the individual's absence from an unoccupied home when he or she intends to return to the property. An absence from the home can be necessary to accomplish a specific purpose such as hospitalization, confinement in a nursing home or receipt of services, such as nursing or personal care services not available to the individual in his or her home.

    (vi) An intent to return home is nullified by any efforts to sell or dispose of the property during the exemption period. The exemption based on the intent to return ends the first day of the month after the month efforts are made to sell or dispose of the homestead property.

    (vii) Rental of a homestead which has been excluded because of intent to return does not nullify the exclusion. The homestead retains the exclusion as long as there is a clear, non-contradictory intent to return, and no efforts are made to sell or dispose of the property. The rent will be counted as unearned income in the month received.

    (viii) The exemption based on residence of the enrollee's dependent relative ends the first day of the month after the relative last lived in the homestead, if the relative does not intend to return. Real property located outside of Tennessee can be excluded from countable resources as homestead property, if there is substantiation of the individual's intent to return to the home or the property is the principal residence of the individual's spouse or dependent relatives.

14. Individual Development Account – Funds, including accrued interest, in the account are excluded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions into the account.

15. Income-Producing Resource - Exclude up to $6,000 of an individual's equity in an income-producing resource if it produces a net annual income to the individual of at least 6 percent (6%) of the property's equity value. If the individual's equity value is greater than $6,000, the amount that exceeds $6,000 is countable towards the resource limit.

(i) If an income-producing resource does not produce a net annual income of at least 6 percent (6%) of the resource's equity value, the entire equity value of the resource is countable.

(ii) If the individual owns more than one piece of income-producing resource and each produces income, each is reviewed to determine whether the 6 percent (6%) test is met. Then the amounts of the individual's equity in all of those properties producing 6 percent (6%) are totaled to determine if the total equity of all properties is $6,000 or less. If the total equity value in the properties that meet the 6 percent (6%) rule is over the $6,000 equity limit, the amount exceeding $6,000 is counted as a resource.

16. Insurance – Exclude Sick and Disability Insurance and Burial Insurance.

17. Items of Unusual Value, Household Goods, and Personal Effects – In general, an item may be considered an item of unusual value if the item is not excluded as a household good or personal effect, and the equity value of the item is greater than $500. An item of unusual value that generates income for the individual is countable. The countable value is determined by applying the Rate of Return test (see Income-Producing Resource above). A personal item of unusual value is excluded. Household Goods and Personal Effects are also excluded.

18. Life Estates – Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title, subject to the following exceptions:

(i) A life estate will be excluded as the home when the property meets the homestead exemption.

(ii) If the property is used in the passive production of income, then the life estate is subject to the Rate of Return test (see, Income-Producing Resource above).

(iii) A life estate will be excluded when ownership is necessary for the production of earned income.

(iv) The terms of the life estate contract prevent the holder from selling his or her interest in the property.

(v) If the life estate is not excluded based on the criteria (i)-(iv) above, the entire value of the life estate is a countable asset. The life estate value is determined by multiplying the Fair Market Value (FMV) of the property by the percentage listed in the SSA's Life Estate and Remainder Interest Tables for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.

(vi) When an individual purchases, or, in some other way receives, as compensation in a transaction, a life estate in another individual's home, the purchase of the life estate is considered an asset transfer subject to penalty, unless the individual then lives in the home for a period of at least one year after receiving the life estate.

(vii) If the individual does live in the home for a period of one year after receiving or purchasing the life estate, then the amount of the transfer is the entire amount used to purchase the life estate.

(viii) If an individual purchases a life estate in another individual's home and then does live there for one year after the purchase, the life estate is an excluded resource while being used as the individual's (or the individual's spouse's) home. However, if payment for a life estate exceeds the FMV of the life estate the difference between the amount paid and the FMV should be treated as an asset transfer. In addition, if an individual makes a gift or transfer of a life estate interest, the value of the life estate should be treated as a transfer of assets.

19. Life Insurance – Countable or excluded based on the type of life insurance owned by the individual and its intended use. Exclude all life insurance if the total face value of all policies does not exceed $1,500 per owner.

20. Livestock – The value of livestock necessary for business or self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. The equity value of livestock that are pets is countable. Livestock that is used as non-business income-producing property is countable, and subject to treatment as an Income-Producing Resource as described in this subparagraph.

21. Oil and Mineral Rights – May be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when the surface rights of the same property are countable (non-homestead, real property).

    (i) If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, the oil and mineral rights are excluded.

    (ii) If oil or mineral rights are producing income to the individual, and he or she is not actively engaged in the production of income, the equity value of the rights is subject to the Rate or Return test. See Income-Producing Resource above.

22. Patient Trust Account – The balance of the account at the time of application and redetermination is a countable resource.

23. Personal – Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and his or her family.

24. Personal Consumption – Exclude up to $6,000 of the equity value of non-business property currently in use to produce goods or services essential to daily activities. Any portion of the property's equity value in excess of $6,000 is a countable resource.

25. PASS - Any income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.

26. Prepayment of Rent – Countable unless the individual cannot receive the money back under any circumstances (i.e., the lease agreement includes a no refund policy, or the landlord provides a statement that the funds will not be returned to the renter). Prepayment of an applicant's mortgage is not considered a resource.

27. Prepayment of Nursing Home Care – Prepayment for care deposited by an applicant upon his admission to a TennCare Medicaid-participating long-term care facility is a countable resource for the individual who is subsequently approved for TennCare Medicaid benefits if the deposit was paid from the individual's own funds.

28. Proceeds from the Sale of a Home - Excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within three (3) months of the date of receipt of the proceeds.

29. Promissory Notes and other Loans – A promissory note or other loan given by the household is considered personal property and is countable, unless the note/loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his or her share in the note or loan. The equity value of the note/loan is countable.

    (i) If a household makes a loan that is considered inaccessible, or is shown to have a significantly lower market value than the unpaid balance of the loan, the loan will be

considered to be an uncompensated transfer of assets. The uncompensated asset transfer will be considered to be the outstanding balance due on the loan as of the date of the lender's application for long term services and supports (nursing facility or HCBS services).

(ii) In addition, the Deficit Reduction Act of 2005 (DRA) provides that funds used to purchase a promissory note, loan or mortgage must meet the following criteria, or else the purchase will be treated as a transfer of assets for less than FMV:

(I) The repayment term must be actuarially sound (as determined by SSA standards);

(II) Payments must be made in equal amounts during the term of the loan with no deferral payment and no balloon payments; and

(III) The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

(iii) If the above criteria are not met, the purchase of the promissory note or loan must be treated as a transfer of assets. The amount used to calculate a penalty will be the outstanding balance of the loan due as of the date of application for TennCare Medicaid.

(iv) Promissory notes that are made for purposes other than personal use are treated according to their use. Promissory notes may be made for the following purposes:

(I) Burial;

(II) Business or Self-Employment; and

(III) Proceeds from the Sale of a Home.

30. Property that represents government authority to engage in an income-producing activity – Excluded if the property is used in trade, business or non-business income-producing activity. Exclude property that is currently not in use due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.

31. Prorated as Income – Excluded.

32. Real Property – The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:

(i) Property excluded as homestead;

(ii) The inaccessible equity value of real property;

(iii) Equity value of income-producing property (subject to the Rate of Return test);

(iv) Real property necessary for the production of earned income (see Business or Self-Employment); and

(v) Property excluded under a Conditional Assistance agreement between the individual and the State.

33. Retirement Accounts and Pension Plans – If retirement benefits are being received out of such accounts, the principal is not considered a resource. If payments are not being received and the account is accessible, then the equity value is countable. The equity value is the cash surrender value minus any early withdrawal penalty.

(i) Funds held in a 401(k) retirement account are countable when the individual or his or her spouse is no longer job-attached because the funds are accessible after employment

terminates. If the individual is still job-attached, the value of the 401(k) is excluded. A 401(k) retirement account owned by a deemed spouse or a deemed parent is excluded as a resource.

(ii) Funds held in an IRA are considered accessible to the individual or community spouse. Count the equity value of an accessible IRA when determining eligibility. IRA funds owned by a community spouse are also considered countable and accessible when determining a CSRMA. IRA funds owned by a deemed spouse (for non-institutional categories) or deemed parent are excluded from the resource determination.

(iii) Keogh plans are considered accessible and counted as resources to the individual or community spouse even if the household is not actually accessing the funds. Keogh funds are countable resources in determining the CSRMA. Keogh plans owned by a deemed spouse (non-institutional Medicaid) or deemed parent are excluded as resources.

34. Savings Accounts – Countable if it is characterized by personal use. If the current month's income has been deposited into the account it must be excluded when determining the current value of the account. A savings account may be excluded if it is used for one of the following purposes:

(i) Burial funds;

(ii) Business or Self-Employment;

(iii) Educational Income;

(iv) Individual Development Account;

(v) PASS;

(vi) Proceeds from the Sale of a Home (subject to time limits);

(vii) Prorated as income;

(viii) Settlement or Disaster Payment, if excluded by policy; and

(ix) SSI/SSA Retroactive Payment (subject to time limits).

35. Settlement or Disaster Payment - Payments or benefits provided under certain Federal statutes are excluded, if payments are not commingled with other funds. Excluded settlement and/or disaster payments include:

(i) Agent Orange Settlement Payments;

(ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;

(iii) Distribution of perpetual judgment funds to Indian tribes under the following:

(I) Indian Judgment Funds Distribution (P.L. 93-134);

(II) Black Feet and Gros Ventre Tribes (P.L. 92-254);

(III) Grand River Band of Ottawa Indians in Indian Claims Commission Docket No. 40-K;

(IV) Tribes of groups under PL 93-134;

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 94-

433); and

(VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL 94-114.

(iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments made to hemophilia patients infected with HIV through blood plasma products as a result of the class action lawsuit;

(v) Filipino Veterans Compensation Fund Payments. Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

(vi) Japanese-American and Aleutian Restitution Payments;

(vii) Payments made to individuals because of their status as victims of Nazi persecutions;

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida;

(ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (State and local payments are only excluded for 9 months);

(x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and

(xi) State funds paid to crime victims (excluded for 9 months).

36. SSI/SSA Retroactive Payment – Excluded for nine months after the payment is received and counted after that nine month exclusion period.

37. Stocks/Bonds/Mutual Funds– Countable. Although personal mutual funds are countable, those held for purposes listed below are subject to different treatment:

(i) Burial;

(ii) Business or Self-Employment;

(iii) Educational Income;

(iv) Proceeds from the Sale of a Home;

(v) Prorated as Income; or

(vi) Settlement or Disaster Payment, if excluded by policy.

38. Tools of the Trade – Excluded.

39. Trusts – Countable or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, plus other factors.

40. Vehicles – One car, truck, motorcycle, camper, motor home, aircraft, snowmobile, watercraft, boat, or all-terrain vehicle is excluded regardless of its value if it is used for transportation of the individual or a member of his or her household. If an applicant owns more than one vehicle, the equity value of that second vehicle is countable when it is owned by the applicant or a deemed filing unit member, and it cannot be excluded under another provision. Boats, motorcycles, snowmobiles, jet skis, ATVs, and aircraft are generally considered recreational vehicles. The equity value of these recreational vehicles is a countable resource unless it can be excluded under other provisions.

(d) Conditional Assistance. Real and personal property, which is not exempt under another resource provision, is exempt as a resource if the individual enters into a Conditional Assistance agreement with the State. The individual must make a bona fide effort to sell the property at its current market value, and repay the State for medical expenses covered by HCFA during the period of conditional assistance.

1. The exclusion period for real property is not to exceed 9 months. The exclusion period for personal property is not to exceed 3 months, however a 3 month extension may be granted if the individual is able to show a good cause for failure to dispose of the property. Property that remains unsold at the end of the exclusion period will be considered inaccessible so long as the individual continues the bona fide effort to sell.

2. Repayment of medical expenses covered by HCFA during the period of conditional assistance may not exceed the total net proceeds of the sale. Any proceeds remaining after the repayment of medical expenses is paid are considered a resource.

(e) Disregards and Expenses Allowed. Unless otherwise specified in Subparagraph (f) below, individuals described in Subparagraph (a) are subject to the following expense requirements.

1. Court Ordered Child Support Payments – Exclude amount actually paid up to the full court-ordered obligation. A child support disregard will not be allowed for the same individual for whom a CSIMA or DIMA is allowed in an Institutionalized Medicaid budget.

2. Legally Obligated Alimony Payments – Alimony is an expense to the payer of the alimony and is allowed when alimony is paid during the month of application. The payments must be in cash, including checks and money orders, to be considered alimony. The following payments are not alimony: child support, noncash property settlements, and payments to keep up the payer's property. Alimony expenses do not include voluntary payments.

3. General Income Disregard – A $20 monthly General Income Disregard is allowed per household, and is applied to unearned income. If any of the $20 disregard is not offset by unearned income, the remainder is applied to the spouse's unearned income and then to the applicant or enrollee's earned income.

4. Child Support Disregard – If the applicant receives child support payments (current only), exclude up to $50 per month of child support payments received if the family also receives TANF benefits.

5. Earned Income Disregard – The first $65 of the earned income of each aged, blind or disabled individual is disregarded.

6. Blind and Disability Related Work Expenses:

(i) The gross countable earned income of each blind or disabled individual (not living in a medical institution) may be reduced by the amount of expenses attributable to earning the income. The allowable Blind Work Expenses (BWE) and allowable Disability Related Work Expenses (DRWE) are not the same. BWE and DRWE apply only to earned income. In order to deduct either BWE or DRWE, the individual must be:

(I) Blind, blind and disabled, or disabled; and under age 65, or

(II) Age 65 and older; and received SSI payments due to blindness or disability the month before attaining age 65.

(ii) These expenses do not apply to the Institutionalized Medicaid categories. Work expenses must not be payable or reimbursable by a third party, such as Medicaid, Medicare or other insurance.

7. One-Half Disregard – If an individual's gross earned income, less any of the following

disregards: General Income Disregard ($20) remainder, Earned Income Disregard ($65), Disabled Work Expense and Impairment-Related Work Expenses (IRWE), is greater than $0, disregard one-half (1/2) of the remainder.

8. Student Earned Income Exclusion (SEIE) – Applies to the earnings of an individual who is under age 22 and regularly attending school. The exclusion may apply to an eligible or ineligible individual, child, spouse, or parent(s). The SEIE monthly amount is determined by the SSA. The SEIE does not apply to children attending elementary school.

(f) Household Composition Rules – Household composition for the ABD categories is governed by the FRR principle. Financial responsibility is limited to spouse to spouse and parent to child. Household composition not only determines which income standard to use, but also how FRR income is "deemed" or available, and the amount of income "deemed" or available to an individual. See 20 CFR §§ 1160, et seq.

1. The following individuals must be included in the applicant's household, if living in the same household:

   (i) The applicant's spouse;

   (ii) The applicant's children under 18 years of age or under 22 years of age if a student;

   (iii) The applicant's parents, for children under 18 years of age or under 22 years of age if a student; and

   (iv) The applicant's siblings that are under 18 years of age or under 22 years of age if a student.

2. Step-children are included in the household when they live in the home and their natural parent is the spouse of the applicant and living in the home. Step-parents are included when they live in the home with the applicant and natural or adopted parent, and are married to the natural or adopted parent. Step-siblings are included when their natural or adopted parent lives in the home and is considered the applicant's step-parent.

3. Financial eligibility is determined based on a household size of one or two. Included household members are the applicant and if applicable, his or her spouse. If there are additional household members, they will be considered in deeming budgets, if appropriate.

4. Parent-to-child deeming applies when a blind or disabled child is living with his parent(s), and a portion of the parent's income and resources may be deemed available to the child and counted as unearned income to the child in determining his TennCare Medicaid eligibility. The parent receives income disregards and allocations in order to meet his own needs and the needs of other children that live in the household. Child and parental allocations are deducted from the parent's income before any income is deemed to the applicant/enrollee. Parental deeming applies to the following TennCare Medicaid categories:

   (i) Medicare Savings Program (QMB, SLMB, QI1 and QDWI);

   (ii) Pickle Passalong Aged and Blind/Disabled.

5. The countable income and resources of an applicant/enrollee's TennCare Medicaid-ineligible spouse living in the home may be deemed available to the applicant/enrollee. Spousal deeming only applies when the spouses share a living arrangement, i.e., live in the community or home together. Spousal deeming applies to the following TennCare Medicaid Categories:

   (i) Medicare Savings Program (QMB, SLMB, QI, and QDWI); and

   (ii) Pickle Passalong Aged and Blind/Disabled.

6. The countable income and resources of a long-term services and supports applicant/enrollee's TennCare Medicaid-ineligible spouse living in the home is made available to the applicant/enrollee under the Spousal Impoverishment rules.

(g) Qualifying Income Trusts (QIT) for Institutional Applicants.

1. 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 a qualified income trust. Funds placed in a QIT that meets the standards set forth below are not treated as available resources or income for purposes of determining the individual's TennCare eligibility.

2. 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/IID waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program.

3. 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/IID care under Medicaid.

4. 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 MIC. However, it is used in determining patient liability during post-eligibility treatment of income. If the applicant/recipient's income that is not placed in a QIT is over the MIC, the individual is not financially eligible for the Institutional category.

5. A valid QIT must meet the following criteria:

(i) 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.

(ii) Each month the trustee shall distribute the entire amount of income transferred into the Trust except for an amount not to exceed $20 for expenses of the Trust.

(iii) The sole beneficiaries of the Trust are the individual for whose benefit the Trust is established and the State of Tennessee. The Trust terminates upon the death of the individual, or when the Trust is no longer required to establish TennCare Medicaid eligibility in the State of Tennessee, or if nursing facility care or HCBS is no longer medically necessary for the individual, or if the individual is no longer receiving such services.

(iv) The Trust must provide that upon the death of the individual or termination of the Trust, whichever occurs sooner, the State of Tennessee 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.

(v) Amounts remaining in the Trust that are owed to the State must be paid to HCFA within three months after the death of the individual or termination of the Trust, whichever is sooner, along with an accounting of the payments from the Trust. HCFA may grant an extension if a written request is submitted within two months of the termination of the Trust.

(vi) This Part applies to an income trust established on or after July 1, 2005, and under the hardship provision in Section 1613 (e) of the Social Security Act (42 U.S.C. § 1382b(e)).

Hardship may be considered to exist when the institutionalized individual or his or her spouse would have resources in excess of the resource limit, is otherwise eligible, and for whom TennCare Medicaid ineligibility would result in loss of essential nursing care which is not available.

(vii) Allowable payments from the Trust include:

(I) Personal Needs Allowance (PNA) – The amount the individual is allowed to retain for his or her personal needs under TennCare Medicaid policies. As of January 1, 2005, this amount is $50 for confinement in a nursing facility or ICF/IID and 300% of the SSI/FBR for HCBS enrollees and Self-Determination Waiver; and 200% of the SSI/FBR for the Arlington and Statewide Waivers.

(II) A deduction of up to $20 for expenses necessary for managing the trust (i.e. bank charges).

(III) CSIMA or DIMA, if applicable.

(IV) Health Insurance Premiums – Allowed when the individual has health insurance other than TennCare Medicaid (for example, Medicare premium or a Medicare supplement policy).

(V) Item D deductions – Payment for types of medical or remedial care recognized under State law, but not covered as medical assistance under TennCare Medicaid.

(viii) Any countable income not placed in the QIT and any Trust income remaining after allowable deductions are made shall be paid monthly to the nursing facility, HCBS provider, or MCO by the individual or from the Trust in an amount not to exceed the Medicaid reimbursement rate. Any excess income not distributed from the Trust shall accumulate in the Trust monthly.

(ix) No other deductions or expenses may be paid from the Trust. Expenses which cannot be paid from the Trust except as specifically provided herein include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past due medical bills and other debts.

(h) Annuities

1. General Rule. Annuities may be counted as a resource or as unearned income, depending on the circumstances of the annuity. If an annuity is determined to be a countable resource, then any payments from the annuity will be excluded as unearned income. If an annuity is an excluded resource, the annuity payments received will be counted as unearned income.

2. Disclosure. Disclosure of annuities is required for all applicants pursuant to 42 U.S.C. § 1396p(e).

(i) If an individual or his or her spouse refuses to disclose information related to an annuity, the individual will be denied Medicaid eligibility based on the individual's failure to cooperate.

(ii) Annuities owned or purchased by individuals applying for long term services and supports are subject to additional requirements. The Deficit Reduction Act of 2005 (DRA) provides that any individual applying for LTSS must:

(I) Disclose any interest that he or she or his or her spouse has in an annuity;

(II) Name the State of Tennessee as the primary remainder beneficiary on all annuities; and

(III) Demonstrate that the purchase or conversion of any annuity which is an excluded resource was not a transfer of assets for less than fair market value (FMV).

3. Value of an Annuity. The value of an annuity is determined by multiplying the total annual payments by the period of the annuity remaining on the date for which value is being determined. If the period of the annuity is based on an annuitant's lifetime, the annual payments are multiplied by the annuitant's life expectancy, see SSA's Period Life Table. If the annuity is a "period certain" annuity, then annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. A letter from the annuity company stating that the annuity has no value is simply a statement of the company's contractual obligations regarding cash value and is irrelevant to the true market value of the annuity. The calculated value of an annuity may be rebutted by providing verified purchase offers from sources in the legitimate business of buying annuities.

4. Treatment as a Resource.

(i) An annuity is exempt as a resource if it meets the requirements of 42 U.S.C. § 1396p(c)(1)(G).

(ii) An annuity is countable as a resource when:

(I) The annuity is owned by the individual receiving or applying for TennCare Medicaid or an ABD-eligible spouse, but the annuity payments are made to someone else;

(II) The individual does not own 100% of the annuity (or the individual and his spouse do not own 100% of the annuity);

(III) The annuity is owned by an ABD ineligible spouse or a community spouse;

(IV) The annuity is owned by a deemed parent and it is not an employment related annuity; or

(V) The annuity does not meet any of the conditions described in Subpart (iv) below.

(iii) If an annuity meeting any of the above conditions is found to be legally inaccessible, it must be reviewed under the transfer of asset policy for individuals applying for long term services and supports.

(iv) An annuity owned by the individual or an ABD-eligible spouse is excluded as a resource if the individual alone or the individual and his ABD-eligible spouse together own 100% of the annuity and the annuity meets all of the following conditions:

(I) The annuity is irrevocable;

(II) The annuity is non-assignable;

(III) The annuity is annuitized;

(IV) The annuity is actuarially sound; and

(V) The payment contract requires period payments of equal amounts.

5. Treatment of Annuities Under Transfer of Assets Requirements. The Deficit Reduction Act provides that individuals applying for Institutionalized Medicaid must also comply with additional requirements related to annuities that are purchased on or after February 8, 2006. In addition, certain transactions, referred to as conversions, made to annuities purchased prior to February 8, 2006, will make the annuity subject to the DRA provisions. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity

and elections to annuitize the contract. Routine changes, change of address or notification of death or divorce of a remainder beneficiary, made to annuities purchased prior to February 8, 2006, do not subject the annuity to the DRA provisions.

(i) Disclosure of Interest in an Annuity.

(I) Individuals applying for long term services and supports must disclose information regarding any interest that the individual or his spouse may have in an annuity. This disclosure requirement applies regardless of whether the annuity is counted as a resource.

(II) If an individual or his spouse refuses to disclose information related to an annuity, the individual will be denied Medicaid eligibility based on the individual's failure to cooperate.

(ii) Requirement to name the State as the Remainder Beneficiary.

(I) Annuities purchased or converted by the individual or his spouse on or after February 8, 2006, must be changed prior to TennCare Medicaid approval or redetermination to name the State of Tennessee as the remainder beneficiary of the annuity, in the following order:

I. Community spouse.
II. A minor child.
III. A blind or disabled adult child.
IV. State of Tennessee.

(II) No individual or entity other than those listed in Item (I) may be named as a beneficiary in a position superior to the State. A community spouse cannot name the institutionalized spouse as a remainder beneficiary of the annuity in a position superior to that of the State.

(III) As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term services and supports and home and community based services. The State must notify the issuer of the State's right as the preferred remainder beneficiary and the issuer must notify the State if there are any changes in the amount of income or principal being withdrawn.

(IV) An annuity may be amended to meet these criteria, so that the annuity purchase will not be treated as a transfer of assets for less than FMV.

(V) The purchase of an annuity is subject to the transfer of assets provision unless it meets the requirements of 42 U.S.C. § 1396(c)(1)(F).

(VI) The purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for long term services and supports shall be treated as a transfer of assets for less than FMV unless the annuity is determined to be a countable resource, or, if it is excluded, it meets the criteria below. This only applies to annuities for which the individual is the annuitant (not the spouse).

(VII) The annuity will not be treated as a transfer of assets if the annuity meets any of the following conditions:

I. The annuity is considered either:

A. An individual retirement annuity (Section 408(b) of the Internal Revenue Code of 1986 (IRC), 26 U.S.C. § 408(b)), or

B. A deemed Individual Retirement Account (IRA) under a qualified employer plan (Section 408(q) of the IRC 26 U.S.C. § 408(q)); or

II. The annuity is purchased with proceeds from one of the following:

A. A traditional IRA, Section 408a of the IRC (26 U.S.C. § 408(a));

B. Certain accounts or trusts which are treated as traditional IRAs, Section 408(c) of the IRC (26 U.S.C. § 408(c));

C. A simplified retirement account, Section 408(p) of the IRC (26 U.S.C. § 408(p));

D. A simplified employee pension, Section 408(k) of the IRC (26 U.S.C. § 408(k)); or

E. A Roth IRA, Section 408A of the IRC (26 U.S.C. § 408(a)); or

III. The annuity meets all of the following requirements:

A. The annuity is irrevocable;

B. The annuity is non-assignable;

C. The annuity is actuarially sound;

D. The annuity provides payments in approximately equal amounts, with no deferred or balloon payments; and

E. Periodic payments are provided to the annuitant.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.07 Family and Child Eligibility Groups.

(1) Caretaker Relatives.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Individual must be a parent or caretaker relative of a minor child and must agree to cooperate with State Child Support Enforcement to establish paternity and medical support, if applicable. Failure to cooperate or show good cause for not cooperating once eligible shall result in termination.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitation: Household income cannot exceed the monthly income levels as outlined in the State Plan. Note: The FFM uses these numbers to establish an equivalent FPL.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(h) Individuals in this category may also be eligible for Extended Medicaid as described in 42 CFR § 435.115 and Transitional Medicaid as described in 42 CFR § 435.112.

(2) TennCare Pregnant Women.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Individual must be pregnant. Self-attestation of pregnancy is accepted unless the State has information that is not reasonably compatible with such attestation.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitation: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level. See Rule 1200-13-20-.06.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(h) Other:

1. Eligibility is continuous through the last day of the month of the 60-day postpartum period as defined at 42 CFR § 435.4, regardless of income changes.

2. An individual in this category is eligible for all medically necessary covered services, other than LTSS, because TennCare considers all medically necessary covered services to be pregnancy-related. A pregnant woman could be eligible for LTSS if she is determined to meet the criteria for an Institutional Medicaid category.

3. Individuals in this category may also be eligible for Extended Medicaid as described in 42 CFR § 435.115 and Transitional Medicaid as described in 42 CFR § 435.112.

(3) Presumptive Eligibility for Pregnant Women.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04. Self-attestation of citizenship, residency and Social Security Number (SSN) are accepted at application for presumptive eligibility.

(c) Special Eligibility Requirements: Individual must be pregnant at the time of application. Self-attestation of pregnancy is accepted unless the State has information that is not reasonably compatible with such attestation.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitation: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level. See Rule 1200-13-20-.06.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: The date of determination by the Tennessee Department of Health or other qualified entity. The presumptive eligibility period ends the earlier of either the last day of the month following the month a presumptive eligibility determination was made or date of determination of a full Medicaid application, as defined in 42 CFR § 435.907, or as otherwise agreed to by the Single State Agency and CMS. Only one presumptive period of eligibility is allowed for each pregnancy.

(4) Infants and Children under Age 19.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Individual must be younger than 19 years of age.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitations:

1. Infants younger than age 1: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level.

2. Children from age 1 to age 5: Household income cannot exceed one hundred forty two percent (142%) of the Federal Poverty Level.

3. Children from age 6 to age 19: Household income cannot exceed one hundred thirty three percent (133%) of the Federal Poverty Level. See Rule 1200-13-20-.06.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: Eligibility begins the on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(h) Individuals in this category may also be eligible for Extended Medicaid as described in 42 CFR § 435.115 and Transitional Medicaid as described in 42 CFR § 435.112.

(5) Deemed Newborns.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04, except Deemed Newborns are not subject to citizenship rules. Newborns without an SSN must be enumerated by age one to remain eligible for another category, or before they can be approved in another category, whichever occurs first.

(c) Special Eligibility Requirements: Newborns must be 12 months or younger. A baby born to a mother eligible for and receiving TennCare Medicaid shall be eligible for TennCare Medicaid for one year from the date of birth, as long as the newborn remains a resident of Tennessee during that time.

(d) Income Limitations: None.

(e) Resource Limitations: None.

(f) Effective Date of Eligibility: The child's date of birth, if mother was eligible for and receiving TennCare Medicaid at the time of birth.

(6) Newborn Presumptive.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04. Self-attestation of residency is accepted at application for presumptive eligibility. SSN is not required for newborns to age 1.

(c) Special Eligibility Requirements: Newborns must be 12 months or younger.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitations: Household income cannot exceed one hundred ninety five percent (195%) of the

Federal Poverty Level.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: The date of determination by the qualified entity. The presumptive eligibility period extends from the date of application through the end of the following month, or if a full Medicaid application is submitted before the end of the month following the presumptive application, eligibility continues until a determination is made on a complete Medicaid application.

(7) Former Foster Care Children up to Age 26.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: The individual must be under age 26, have been in foster care provided by the State of Tennessee, and must have been receiving Medicaid in the foster care category at the time he aged out of custody in order to qualify for this category.

(d) Income Limitations: None.

(e) Resource Limitations: None.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(8) Standard Child Uninsured.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Must be a Medicaid "Rollover" enrollee as defined in 1200-13-20-.02, or currently enrolled in TennCare Standard, and does not have insurance or access to health insurance.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitations: Household income must be at or below two hundred eleven percent (211%) of the Federal Poverty Level. See Rule 1200-13-20-.04.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: The day following the TennCare Medicaid coverage end date.

(h) Other: Includes uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below two hundred percent (200%) of the Federal Poverty Level, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. If a person loses eligibility in this category, he or she will not be able to re-enroll in it.

(9) Standard Child Medically Eligible.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Must be an uninsured child under age 19 who is losing eligibility for Medicaid or being renewed as TennCare Standard, who does not have access to health insurance,

and who has been determined to have a qualifying medical condition in accordance with these rules.

(d) Special Application Procedures:

1. Must be a Medicaid "Rollover" enrollee as defined in 1200-13-20-.02, or currently enrolled in TennCare Standard.

2. Applicants have three (3) options for proving medical eligibility:

(i) Option 1: Physician's attestation on the Medically Eligible (ME) Packet of specific qualifying conditions.

(ii) Option 2: A completed ME packet and medical records to support a qualifying medical condition with a signed release for medical records in the event additional medical records are needed.

(iii) Option 3: An existing Medically Eligible determination in Interchange.

3. If a Medicaid enrollee under age nineteen (19) whose Medicaid eligibility is ending is determined to otherwise meet technical eligibility requirements for TennCare Standard, but is not eligible as uninsured because his income is above two hundred eleven percent (211%) of poverty, he will be sent a medically eligible packet.

4. TennCare will send the enrollee a medical eligibility packet with an explanation regarding how to apply for TennCare Standard as a medically eligible person. The enrollee will have sixty (60) days from the date of the notice letter (inclusive of mail time) to submit his medical eligibility packet. If the individual is determined to qualify as medically eligible, coverage will be provided throughout the eligibility determination period and will continue with no break.

5. The required medical eligibility application information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A medical eligibility form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the sixtieth (60th) day will be denied with a notice of appeal rights.

(e) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(f) Income Limitations: Household income must exceed two hundred eleven percent (211%) of the Federal Poverty Level. See Rule 1200-13-20-.06.

(g) Resource Limitations: None.

(h) Effective Date of Eligibility: The day following the TennCare Medicaid coverage end date.

(10) CoverKids - CHIP Children under age 19.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Includes children under age 19 who do not have health insurance coverage, as defined in rule 1200-13-20-.02.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitations: Must be over the applicable Medicaid limit and under two hundred fifty percent (250%) of the Federal Poverty Level. See Rule 1200-13-20-.06.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(11) CoverKids Pregnant Women/Unborn Children.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04. The pregnant woman's unborn child is presumed to be a U.S. citizen, regardless of the citizenship or immigration status of the mother. The mother is not required to provide proof of citizenship or immigration status.

(c) Special Eligibility Requirements: Includes pregnant women who do not have health insurance coverage, as defined in rule 1200-13-20-.02, or do not have maternity benefits or have exhausted maternity benefits.

(d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(e) Income Limitations: Must be ineligible for Medicaid and below two hundred fifty percent (250%) of the Federal Poverty Level. See Rule 1200-13-20-.06.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(h) Other: Eligibility for the pregnant woman is continuous through the 60 days postpartum period as defined at 42 CFR § 435.4. Eligibility for the newborn child continues twelve (12) months from the mother's effective date of eligibility.

(12) IE Foster Care, Foster Care, and Adoption Assistance.

(a) Definition: Children in State foster care or in a subsidized adoptive home.

(b) Eligibility for these categories is determined by the Tennessee Department of Children's Services.

(13) Transitional Medicaid.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements for Transitional Medicaid: Eligible individuals must have been eligible for and receiving benefits for at least three of the six months immediately preceding the month of ineligibility. Eligible individuals receive twelve months of Medicaid.

(d) Special Eligibility Requirements for children: Transitional Medicaid benefits are provided to children who lose Child MAGI eligibility when the following conditions are met:

1. The child's parent or caretaker relative was previously eligible in a MAGI category with income under the Caretaker Relative income standard for three of the previous six months but lost eligibility due to an increase in earnings; and

2. The child was eligible and enrolled in a Child MAGI category for three of the six months immediately preceding the month the parent or caretaker relative lost eligibility.

(e) Special Eligibility Requirements for Pregnant women: Transitional Medicaid benefits are provided to pregnant women who lose Pregnancy MAGI eligibility when all of the following conditions are met:

1. The individual was eligible and enrolled in the Pregnancy MAGI category for three of the six months immediately preceding the month eligibility was lost;

2. The woman's loss of eligibility is due to an increase in earnings; and

3. The woman's household income was at or below the Caretaker Relative income standard for three of the six months immediately preceding the month eligibility was lost.

(f) Special Eligibility Requirements for Caretaker Relatives: Transitional Medicaid benefits are provided to parents and caretaker relatives who lose Caretaker Relative MAGI eligibility when all of the following conditions are met:

1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three of the six months immediately preceding the month eligibility was lost;

2. Loss of eligibility was due to an increase in earnings; and

3. The parent or caretaker relative must continue to have a dependent child in the home in order to receive Transitional Medicaid.

(g) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(h) Income Limitations: See Rule 1200-13-20-.06.

(14) Extended Medicaid.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Eligible individuals must have been eligible for and receiving benefits for at least three out of six months immediately preceding the month of ineligibility. Eligible individuals receive twelve months of Medicaid.

(d) Special Eligibility Requirements for children: Extended Medicaid benefits are provided to children who lose Child MAGI eligibility when the following conditions are met:

1. The child's parent or caretaker relative was previously eligible in a MAGI category with income under the Caretaker Relative income standard for three of the previous six months but lost eligibility due to an increase in spousal support; and

2. The child was eligible and enrolled in a Child MAGI category for three of the six months immediately preceding the month the parent or caretaker relative lost eligibility.

(e) Special Eligibility Requirements for Pregnant women: Extended Medicaid benefits are provided to pregnant women who lose Pregnancy MAGI eligibility when the following conditions are met:

1. The individual was eligible and enrolled in the Pregnancy MAGI category for three of the six months immediately preceding the month eligibility was lost;

2. The woman's loss of eligibility is due to an increase in spousal support; and

3. The woman's household income was at or below the Caretaker Relative income standard for three of the six months immediately preceding the month eligibility was lost.

(f) Special Eligibility Requirements for Caretaker Relatives: Extended Medicaid benefits are provided to parents and caretaker relatives who lose Caretaker Relative MAGI eligibility when the following conditions are met:

1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three of the six months immediately preceding the month eligibility was lost;

2. Loss of eligibility was due to an increase in spousal support; and

3. The parent or caretaker relative must continue to have a dependent child in the home in order to receive Transitional Medicaid.

(g) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.

(h) Income Limitations: See Rule 1200-13-20-.06.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.08 Aged, Blind or Disabled Categories.

(1) Supplementary Security Income (SSI) Cash recipient.

(a) Aged, blind or disabled individuals who are determined eligible for SSI payments by the SSA. If individuals are determined eligible for SSI payments in Tennessee by the SSA, they are eligible for TennCare Medicaid. Once SSI payments in Tennessee stop, the individual becomes an inactive SSI enrollee who must be reviewed for eligibility in all other categories.

(b) Effective date of eligibility: Date determined eligible for SSI by SSA.

(2) Disabled Adult Child

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: Disabled adult children who lose SSI eligibility after July 1, 1987 because of the receipt of or an increase in benefits for DAC payments under Title II of the Social Security Act will remain eligible for Medicaid if the initial entitlement under Title II above and/or cost of living increases, whichever caused the ineligibility for SSI, were disregarded.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000 for an individual, $3,000 for a couple.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(3) Pickle Passalong.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: TennCare Medicaid benefits are available to individuals who would be eligible for SSI payments if increases in their Social Security benefits due to Cost-of Living Adjustments being disregarded. Individuals who meet all other non-financial and financial eligibility requirements remain eligible for TennCare Medicaid if they:

1. Were eligible for and received both Social Security and SSI benefits in the same month since April 1977. The SSI recipient who receives Social Security retroactive benefits is considered for TennCare Medicaid purposes to have received SSI and Social Security benefits in the same month, if Social Security eligibility overlaps a month the individual also received SSI benefits;

2. Lost eligibility for SSI since April 1977;

3. Currently receive Social Security benefits authorized under Title II of the Social Security Act; and

4. Have countable income equal to or less than the current SSI Federal Benefit Rate after all applicable cost-of-living adjustments have been deducted.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000 for an individual, $3,000 for a couple.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(4) Widow/Widower.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements. A disabled widow/widower is eligible for TennCare Medicaid for any month in which he is entitled to a Social Security Widow/Widower benefit, but is not eligible for SSI, if he:

(i) Was eligible for SSI based on his own disability;

(ii) Was entitled to the Social Security Widow/Widower benefit any time after the age of 50;

(iii) Lost SSI eligibility in the first month that the Social Security Widow/Widower benefit was paid;

(iv) Has been continuously entitled to the Social Security Widow/Widower benefit from the month that the SSI was authorized;

(v) Would be eligible for SSI if the Widow/Widower entitlement and all subsequent COLAs were disregarded;

(vi) Is not entitled to Medicare Part A; and

(vii) Is at least age 50 and up to age 65.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000 for an individual, $3,000 for a couple.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(5) Institutional Medicaid.

(a) Definition: See Rule 1200-13-20-.02.

(b) Technical Requirements: See Rule 1200-13-20-.04.

(c) Special Eligibility Requirements: To gain eligibility in this category, applicants must either be determined to meet the medical (level of care) eligibility criteria for CHOICES to receive payments for long term services and supports through the CHOICES Group 1 or Group 2 benefits package or be continuously confined in an institution for 30 consecutive days. Receipt of hospice services in a

nursing facility for any length of time meets the 30-day continuous confinement requirement.

(d) Household size is based upon the Aged, Blind, and Disabled household composition rules at 1200-13-20-.06.

(e) Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual.

(f) Resource Limitations: Resources shall not exceed $2,000 for an individual or $3,000 for a couple.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(h) Special Asset Rules:

1. Asset Disregards for Qualified Long-Term Care Insurance Policies.

   (i) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare. TennCare 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.

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

   (iii) 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.

2. Entrance Fees: 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 be met in order for the entrance fee to be considered an available resource:

   (i) 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;

   (ii) 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

   (iii) The entrance fee does not confer an ownership interest in the community.

3. Funds used to purchase a loan, mortgage or promissory note after February 8, 2006 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 part, the value of the home will be the outstanding balance due as of the date of the application for Medicaid.

4. 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.

(i) Transfer of Assets – An applicant for Institutional Medicaid shall not transfer assets for less than fair market value during the sixty (60) months prior to the date of application. If an individual is found to have transferred an asset for less than fair market value, he will be ineligible for payments for Long-Term Services and Supports.

1. An individual shall not receive a period of ineligibility to the extent that:

(i) The asset transferred was a home and title to the home was transferred to:

(I) The spouse of the individual;

(II) A child of the individual who is younger than age 21 or blind and permanently and totally disabled;

(III) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(IV) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual.

(ii) The assets:

(I) Were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

(II) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(III) Were transferred to, or to a trust established solely for the benefit of, the individual's blind or permanently disabled child; or

(IV) Were transferred to a trust established pursuant to 42 U.S.C. § 1396p(d)(4).

(iii) A satisfactory showing is made that:

(I) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration;

(II) The assets were transferred exclusively for a purpose other than to qualify for medical assistance;

(III) All assets transferred for less than fair market value have been returned to the individual; or

(IV) The denial of eligibility for Long-Term Services and Supports would work an undue hardship on the individual as defined in this rule.

2. 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:

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

(ii) If the institutionalized individual, his 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 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.

(iii) 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, if it occurred within sixty (60) months of application for institutional care.

(j) Penalty for transfer of assets.

1. The institutionalized individual may be subject to penalty if the transfer was completed by the individual; 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 spouse.

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

3. Penalty period: The period of ineligibility for payments for long-term services and supports in the CHOICES Program imposed for transfers of assets within sixty (60) months prior to application for long term care nursing services.

(i) Determined by dividing the uncompensated value of the transferred asset by the average daily 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.

(ii) The penalty period for individuals receiving nursing home care begins the month the individual becomes eligible for LTSS through the CHOICES Program or the month of the transfer, whichever is later. The penalty period for HCBS begins the date of application or the date of the transfer for individuals already receiving HCBS. 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 notice of penalty. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.

(iii) Applicants for, or enrollees in, nursing home coverage can still remain eligible in an Institutional Medicaid category while payments for LTSS are withheld. Applicants for, or enrollees in, home and community-based services cannot be eligible for an Institutional Medicaid category while subject to the period of ineligibility.

(iv) Penalty periods for more than one transferred asset will run consecutively, not concurrently. Any uncompensated value from multiple transfers is added to the initial uncompensated value if penalty periods overlap to determine the consecutive penalty period.

(k) Undue hardship.

1. Undue Hardship shall exist only when:

(i) 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 food, clothing, shelter, or other necessities of life;

(ii) The institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations, and

(iii) The necessary care is not available from any other source.

2. 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. TennCare will determine whether hardship exists and notify the applicant/recipient within thirty (30) days of filing.

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

(I) Patient Liability - Individuals determined eligible for Institutional Medicaid are required to contribute to the cost of their care as a resident in a nursing facility or as a Home and Community Based Services (HCBS) recipient.

1. Patient liability is determined by allowing the following deductions from the individual's gross income:

(i) A Personal Needs Allowance (PNA) for clothing and other personal needs while receiving Institutional Medicaid. Apply the appropriate PNA based on the type of long term services and supports the individual receives, in accordance with the following:

(I) Nursing Facility. $50 PNA from the gross income of an individual in nursing facility.

(II) HCBS, PACE and Self-Determination ID Waivers. PNA is 300% of the SSI FBR.

(III) Statewide ID and Comprehensive Aggregate Cap ID Waivers. PNA is 200% of the SSI FBR.

(ii) An allowance equivalent to the monthly fee for maintenance of a QIT, if applicable.

(iii) A CSIMA for institutionalized individuals with a spouse residing in the community.

(iv) A DIMA for institutionalized individuals with a dependent residing in the community.

(v) Health insurance premiums, coinsurance and deductibles.

(vi) Expenses for medical services as defined at 42 CFR §§ 435.725(c)(4) and 726(c)(4).

2. Community Spouse Income Maintenance Allowance (CSIMA) – When determining an institutionalized individual's patient liability, an allowance is deducted from his or her income for the needs of the community spouse. The CSIMA is allowed unless specifically refused by the institutionalized spouse. Funds must actually be transferred to the community spouse in order to be deducted.

(i) CSIMA is allowed under the following conditions:

(I) CSIMA is not allowed if both spouses are receiving Institutional Medicaid, unless one spouse is receiving HCBS.

(II) If the community spouse applies for TennCare Medicaid, the CSIMA will be counted as unearned income at the time of application.

(III) A community spouse receiving need-based assistance does not have to accept the total or any of the income allocation if it will result in the termination or decrease of those benefits.

(IV) If a couple is married but living separately, and considers themselves to be separated, the CSIMA may be allowed if both individuals agree to the allocation and the community spouse is not institutionalized.

(V) If the community spouse lives out of State, the CSIMA is allowed if the community spouse can be located and the couple is still married.

(ii) CSIMA Terms and Standards:

(I) Standard Maintenance Amount (SMA): The minimum monthly amount of income, as determined by CMS, that the Community Spouse must receive to meet basic needs. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

(II) Maximum Maintenance Needs Allowance (MMNA): The maximum monthly amount of income, as determined by CMS, that the Community Spouse canreceive as a CSIMA. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

(III) Standard Utility Amount (SUA): The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, then it is considered to cover all utilities, including garbage, water, lighting, etc. The SUA is subject to annual change by the Tennessee Department of Human Services.

(IV) Standard Housing Allowance (SHA): The SHA is used to determine whether the community spouse requires an Excess Shelter Allowance. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

(iii) CSIMA Calculation: The CSIMA is calculated using three steps:

(I) Determine Excess Shelter Allowance (ESA).

I. An ESA is allowed when the total shelter costs for rent, mortgage, taxes and insurance, maintenance charges and utility costs exceed the SHA. The SHA is 30% of the Standard Maintenance Amount.

II. The SUA is used when the community spouse is responsible for heating or cooling costs. If the SUA is used then it is considered to cover all utilities (no additional allowance for garbage, telephone, etc.). When there is no or reduced cost to the community spouse because the cost of a particular utility is paid by a third party (in cash or in-kind), reduce the amount of the SUA by the third party payment.

III. To determine the ESA, add rent, mortgages, taxes, insurance, etc., to the SUA, then subtract the SHA.

(II) Determine Community Spouse Net Income. Defined as income over which the Community Spouse has control and which is actually available to him. Child support payments and other types of court-ordered payments made by the Community Spouse are not considered income available to the Community Spouse.

(III) Calculate CSIMA: The CSIMA is calculated by adding the SMA and the ESA, and then subtracting the Community Spouse's net income.

3. Dependent Income Maintenance Allowance (DIMA): When determining patient liability, an allowance is deducted from the individual's income for the needs of his dependents.

   (i) Dependent relatives include all persons who can be or are being claimed as tax dependents.

   (ii) A DIMA is not allowed for any dependent receiving HCBS or who is institutionalized.

   (iii) Pursuant to the Medicare Catastrophic Coverage Act, a dependent does not have the option of declining all or a portion of the income allocation for any reason, even if needs-based benefits may be decreased or lost because of the allocation.

   (iv) The total of both the CSIMA and DIMA combined cannot exceed the MMNA.

   (v) The MMNA for each additional dependent family member is equal to one-third of the difference between the SMA and the dependent's gross income.

   (vi) DIMA Calculation: The dependent allocation(s) equals the SMA for the community spouse minus the dependent's own gross countable income divided by 3.

4. Item D Expenses: Expenses for medical or remedial care not subject to third party payment as defined at 42 CFR §§ 435.725(c)(4), .726(c)(4) and .832, and outlined in the State Plan are allowable deductions. Criteria for Deduction of an Item D Expense:

   (i) The expense must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, the client's spouse or family or medical trust fund, Medicare, etc.

   (ii) The expense may be unpaid or paid by the client during the month(s) of eligibility determination or paid by a member of the client's family and reimbursement is expected by the family member.

   (iii) The expense must not have been allowed previously as an allowed necessary item.

   (iv) If payment for the item is outstanding, it must be considered collectible by the party who provided the medical service and one for which the client is legally liable.

   (v) Medical expenses incurred during TennCare Medicaid ineligibility do not impact whether the bill is an allowable medical expense.

   (vi) Deductions will be allowed in accordance with 42 CFR §§ 435.725(c)(4), .726(c)(4, and .832, and the State Plan.

(m) Resource Assessment and CSRMA.

1. Resource Assessment: When determining eligibility for a married institutionalized applicant, a calculated amount of the couple's assets is allocated to the community spouse in order to be used for his/her own needs. The resource assessment is a snapshot of all countable assets owned by the couple at the time the individual enters the nursing facility but conducted when the individual applies or when an assessment is requested prior to application. All of the countable resources owned individually or jointly by both spouses are counted; resources excluded under the ABD resource rules are not counted in the resource assessment.

   (i) Only one resource assessment will be completed for a married couple.

   (ii) Under no circumstances can a resource assessment be completed prior to the date of admission to a long term care facility or enrollment in an HCBS waiver.

   (iii) An assessment remains in effect until a HCFA application is filed, regardless of any

interruptions in long-term care. If a resource assessment is completed and the individual applies for TennCare Medicaid, but is found ineligible, the original resource assessment is still valid if the individual applies again in the future.

2. Community Spouse Resource Maintenance Allowance: The CSRMA is based on the spouses' combined countable resources documented in the Resource Assessment. The amount of the CSMRA is the greater of:

   (i) One-half (1/2) of the total countable resources, but not less than the Minimum Resource Standard or greater than the Maximum Resource Standard (released in the SSI and Spousal Impoverishment Standards and subject to change annually);

   (ii) The court-ordered amount; or

   (iii) The amount determined by a HCFA Eligibility Appeals Administrative Judge due to a hardship situation (extreme financial duress).

3. When an application is filed by or on behalf of the spouse seeking LTSS, the CSRMA amount determined in the resource assessment is the amount allocated to the community spouse. This amount is deducted from the combined resources of both spouses as of the first day of the first month for which assistance is requested. None of the community spouse's share of the resources is considered available to the individual seeking eligibility when determining his or her TennCare Medicaid eligibility.

4. Refusal of CSRMA. - A community spouse who receives needs-based assistance may accept or decline all, some or none of the CSRMA if the allocation would cause the loss of or decrease in those program benefits. If the community spouse accepts only a portion of the CSRMA, the unclaimed portion of the CSRMA is counted as part of the institutionalized spouse's resources.

5. Resource Transfer as a Result of Assessment.

   (i) CSRMA "Grace Period" - Following a resource assessment and initial approval of eligibility, resources must be transferred within twelve (12) months of the approval. Both spouses must agree to the transfer in order to use the institutionalized spouse's share in determining his or her eligibility. The transfer may require conveyance of resources from the institutionalized individual to the community spouse, or vice versa.

   (ii) Transfer Refusal - When the community spouse refuses to transfer resources to the institutionalized individual, the institutionalized spouse may still be eligible if on appeal the State finds that undue hardship circumstances exist.

      (I) If the community spouse has available assets over the CSRMA he or she is legally obligated to provide support.

      (II) Hardship cannot be determined to exist unless assets have been reallocated as the result of an appeal decision or a court order.

   (iii) CSRMA Appeals.

      (I) When the Individual and/or Spouse Has Appeal Rights - Appeal rights are considered only after a HCFA application has been filed and either spouse alleges that the assessment or eligibility determination decision is not correct. An assessment completed exclusive of a filed application cannot be appealed. Revisions to the spousal allowance of resources can be made by an HCFA Eligibility Appeals Administrative Judge or by court order.

      (II) CSRMA Revisions - The amount of the CSRMA may only be revised by an HCFA Eligibility Appeals Administrative Judge or by court order, and only if additional verification/documentation is provided. The CSRMA may only be revised when:

I. The initial assessment was alleged to be incorrect and the HCFA Eligibility Appeals Administrative Judge confirms the allegations.

II. The community spouse's income, including the CSIMA, is inadequate to meet the basic standard maintenance amount.

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

I. When Additional Resources May be Allocated to Community Spouse: An HCFA Eligibility Appeals Administrative Judge may determine a larger CSRMA if necessary to offset a CSIMA that is below the required SMA. In the event that the institutionalized spouse does not have enough income to provide the community spouse with the SMA, and the couple has additional resources above the community spouse's protected amount (CSRMA), some or all of the institutionalized individual's resources can be allocated to the community spouse.

II. The Deficit Reduction Act (DRA) of 2005 requires all States to allocate the maximum amount of available income of the institutionalized spouse to the community spouse before granting an increase in the CSRMA. This is referred to as the "income-first" method.

III. Procedure: HCFA uses the Single Fixed Annuity model to address appeals when there is insufficient income to provide the community spouse with the minimum required CSIMA and the couple has additional resources. A single fixed annuity can turn a portion of an individual's savings into income payments made for the rest of the individual's life. The procedure for establishing a Single Fixed Annuity is listed below.

A. Additional resources may be allocated to the community spouse through the HCFA eligibility appeals process to make up any shortfall between the amount of income allocated from the institutional spouse to the community spouse and the SMA, if determined appropriate.

B. The amount of additional resources that are necessary to cover the income shortfall shall be determined in reference to the purchase of a Single Premium Annuity as follows:

(A) By calculating the shortfall between the amount of income allocated and the SMA, and then 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.

(B) The amount of resources needed to cover the shortfall shall be determined in reference to an annuity calculator as adopted by the HCFA.

(C) The additional resource allocation to the community spouse does not require the actual purchase of a Single Premium Annuity that is used for purposes of calculating the amount of the additional resource allocation.

(D) The amount of the community spouse's protected resources shall be excluded from this calculation.

(E) 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.

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

(iv) Transfer of Assets for Less than Fair Market Value.

(I) A transfer of assets for less than fair market value is not considered to have occurred when resources are transferred from the institutionalized individual to the community spouse or vice versa in accordance with a completed resource assessment.

(II) Should the spouse who received the allocation in accordance with the resource assessment then transfer the resource to someone else for less than fair market value, the transfer will be treated as a transfer of assets by the institutionalized individual.

(III) Transfer of assets for less than fair market value is considered part of the application process whether or not a resource assessment has been requested previously or is requested at application. Transfer of assets is not considered if a resource assessment only (no TennCare Medicaid application filed concurrently) is requested.

(6) Medicare Savings Programs.

(a) QMB.

1. Definition: See Rule 1200-13-20-.02.

2. Eligibility for this program is not Medicaid coverage. An individual eligible for QMB is eligible for TennCare Buy-in of their Medicare premiums, and payment of Medicare coinsurance and deductibles.

3. Technical Requirements: See Rule 1200-13-20-.04.

4. Household size is based upon the ABD household composition rules at 1200-13-20-.06.

5. Income Limitations: Below 100% of the FPL.

6. Resource Limitations: Limits for an individual and couple as determined by SSA.

7. Effective Date: First day of the month following the month in which the application is approved.

(b) SLMB.

1. Definition: See Rule 1200-13-20-.02.

2. Eligibility for this program is not Medicaid coverage. An individual eligible for SLMB is eligible for TennCare Buy-in of their Medicare Part B premiums.

3. Technical Requirements: See Rule 1200-13-20-.04.

4. Household size is based upon the ABD household composition rules at 1200-13-20-.06.

5. Income Limitations: Over 100% but less than 120% of the FPL.

6. Resource Limitations: Limits for an individual and couple as determined by SSA.

7. Effective Date: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(c) QI1.

1. Definition: See Rule 1200-13-20-.02.

2. Eligibility for this program is not Medicaid coverage. An individual eligible for QI1 is eligible for TennCare Buy-in of their Medicare Part B premiums, pursuant to State allocation of federal funds. Individuals may not be receiving TennCare Medicaid.

3. Technical Requirements: See Rule 1200-13-20-.04.

4. Household size is based upon the ABD household composition rules at 1200-13-20-.06.

5. Income Limitations: Over 120% but less than 135% of FPL.

6. Resource Limitations: Limits for an individual and couple as determined by the SSA.

7. Effective Date: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(d) QDWI.

1. Definition: See Rule 1200-13-20-.02.

2. Eligibility for this program is not Medicaid coverage. An individual eligible for QDWI is eligible for TennCare Buy-in of their Medicare Part A premiums, but not for Part B premiums.

3. Technical Requirements: See Rule 1200-13-20-.04.

4. Special Eligibility Requirements: Individuals must be under age 65, have a disabling impairment as determined by the SSA, and be eligible to enroll in Medicare Part A but no longer entitled to free Medicare Part A due to substantial gainful activity.

5. Household size is based upon the ABD household composition rules at 1200-13-20-.06.

6. Income Limitations: 200% of FPL.

7. Resource Limitations: Resources not exceeding twice the maximum for SSI.

8. Effective Date: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(7) Other.

(a) Medically Needy Children and Pregnant Women.

1. Definition: See Rule 1200-13-20-.02.

2. Technical Requirements: See Rule 1200-13-20-.04.

3. Special Eligibility Requirements: Applicants for the Medically Needy Pregnant Woman category must be pregnant at the time of application. Applicants for the Child Medically Needy category must be under age 21.

4. Household size is based upon the AFDC-Related household composition information set out in rule .06.

5. Income Limitations: Household income must be less than or equal to the MNIS, based on household size. When household income exceeds the MNIS, based on household size, the individual must meet a spend-down obligation as outlined in the State Plan. See Rule 1200-13-20-.06.

6. Resource Limitations: Medically Needy applicants are permitted to retain resources not to exceed $2,000 for an individual, $3,000 for two individuals and an additional $100 is added per additional person. See 1200-13-20-.06.

7. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05 or the date all eligibility requirements are met, whichever is later.

8. Other: Pregnant women enrolled in the Medically Needy program shall receive continuous coverage through two months postpartum, regardless of income changes.

(b) Breast and Cervical Cancer Category of Eligibility.

1. Definition: See Rule 1200-13-20-.02.

2. Technical Requirements: See Rule 1200-13-20-.04.

3. Special Eligibility Requirements:

(i) Individuals must be younger than age 65 and must lack health insurance that will cover treatment for breast and/or cervical cancer. Once third party coverage of cancer has been exhausted, applicant will be considered to no longer have health insurance.

(ii) Individuals must first be screened and approved by the Department of Health's BCCP.

(iii) Individuals must be actively undergoing treatment for breast or cervical cancer. A Treatment Plan Form signed by the applicant's physician must be submitted to TennCare. Individuals who are determined to require only routine monitoring services for a precancerous breast or cervical condition are not considered to need treatment for purposes of this section. Surveillance after treatment of cancer (breast or cervical) will not qualify as treatment for purposes of this section.

4. Income Limitations: Income cannot exceed two hundred fifty percent (250%) of the FPL, as determined by the Department of Health through its BCCP.

5. Resource Limitations: None.

6. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(c) Presumptive Breast or Cervical Cancer.

1. Definition: See Rule 1200-13-20-.02.

2. Technical Requirements: See Rule 1200-13-20-.04.

3. Special Eligibility Requirements:

(i) Individual must be determined to be presumptively eligible by the Department of Health.

(ii) Individual must be younger than age 65 and must lack access to health insurance that will cover treatment for breast and/or cervical cancer.

(iii) The presumptive eligibility period will last either until the end of the month following the

month of application or determination of a full Medicaid application, as defined in 42 U.S.C. § 1396r-1b.

4. Income Limitations: Income cannot exceed two hundred fifty percent (250%) of the FPL, as determined by the Department of Health through its BCCP program.

5. Resource Limitations: None.

6. Effective Date of Eligibility: The date eligibility is determined by the Tennessee Department of Health.

(d) Payment for Emergency Medical Services.

1. Definition: See Rule 1200-13-20-.02.

2. Technical Requirements: See Rule 1200-13-20-.04. Individuals must meet eligibility requirements for a Medicaid category except for citizenship and enumeration.

3. Special Eligibility Requirements: Individuals who meet all eligibility criteria except citizenship and immigration status for the following TennCare categories of eligibility:

(i) Caretaker Relative;

(ii) Infants and Children Under Age 19;

(iii) Pregnant Woman; or

(iv) Child or Qualified Pregnant Woman Medically Needy.

4. Individuals in one of the above categories may qualify for payment for emergency medical services in which the individual has a medical condition, including labor and delivery, manifested by acute symptoms of sufficient severity which, if not attended to immediately, could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Severe impairment to bodily functions: or

(iii) Serious dysfunction of any bodily organ or part.

5. Household size is based upon the appropriate TennCare category for which the enrollee is seeking coverage.

6. Income Limitations: Must meet financial criteria of one of the respective TennCare categories (Caretaker Relative, Infants and Children Under Age 19, TennCare Pregnant Woman, or Child or Qualified Pregnant Woman Medically Needy).

7. Resource Limitations: If an individual would be otherwise eligible for a Medically Needy category except for citizenship or immigration status, then the individual's resource limits are identical to those found in rule .06, AFDC-Related Financial Determinations. If an individual would be otherwise eligible for a MAGI category except for citizenship or immigration status, then the individual's resources are not considered.

8. Effective Date of Eligibility: Eligibility will not begin prior to the date of admission, nor will coverage begin prior to the date of application, and will be limited to the length of time required to stabilize the emergent episode, as defined at 42 CFR § 440.255. Only the services involved in the emergency itself will be reimbursed and coverage is only provided for the single episode of care.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.09 Redetermination and Termination.

(1) Redetermination of eligibility for CoverKids, TennCare Medicaid's Core Medicaid Population, and TennCare Standard.

(a) Redetermination or renewal is the process of verifying whether an enrollee continues to meet the eligibility requirements of a particular HCFA program.

1. A TennCare Medicaid, TennCare Standard or CoverKids enrollee must have eligibility redetermined once every 12 months, and no more frequently than once every 12 months, absent a waiver from CMS.

2. Redetermination dates are set 12 months from the date the individual is determined eligible for TennCare Medicaid, TennCare Standard or CoverKids, or as otherwise agreed between the Single State Agency and CMS.

(b) Enrollees eligible for TennCare Medicaid as a result of being eligible for SSI benefits shall follow the Redetermination requirements of the SSA. Once SSI benefits are terminated, these enrollees will be reviewed by the State for eligibility in all other categories prior to termination.

(c) An enrollee's TennCare Medicaid, TennCare Standard or CoverKids eligibility shall be redetermined as required by the appropriate category of medical assistance as described in this chapter, unless otherwise agreed to by the Single State Agency and CMS. Prior to the termination of TennCare Medicaid, TennCare Standard or CoverKids eligibility, eligibility will be redetermined in accordance with the following process:

1. HCFA will redetermine eligibility prior to the expiration of the enrollee's current eligibility period.

2. HCFA will issue a renewal packet to redetermine eligibility. TennCare Medicaid, TennCare Standard or CoverKids enrollees will be given forty (40) days, inclusive of mail time, from the date the notice is mailed to return the completed renewal packet to HCFA. The mail date will be the date on the notice. The enrollee may provide information by mail, fax or in-person.

3. Enrollees with a physical health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the renewal form. Enrollees with limited English proficiency will have the opportunity to request translation assistance for responding to the renewal form.

4. HCFA will use the individual's responses in the renewal packet to complete redetermination. HCFA will request additional verification, as needed, to complete redetermination. The request for additional information or verification will provide the enrollee with twenty (20) days, inclusive of mail time, to submit the requested information.

5. If HCFA is able to renew eligibility in a TennCare Medicaid, TennCare Standard or CoverKids category based on information provided in the renewal packet, in addition to information known to HCFA and requested verifications, the agency will notify the enrollee and enroll him in the new appropriate category.

6. Enrollees who respond to the renewal form within the forty (40) day period shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while HCFA reviews their eligibility for open Medicaid categories and CoverKids. If HCFA determines that the enrollee is eligible for a TennCare Medicaid, TennCare Standard or CoverKids category, the agency will notify the individual as follows:

(i) If HCFA determines that the enrollee is eligible for an open TennCare Medicaid category, the agency will notify the enrollee and he will be enrolled in the appropriate category. The

previous category will be closed with no further notice to the enrollee.

(ii) If HCFA determines that the enrollee is eligible for a TennCare Standard category, the agency will notify the enrollee and he will be enrolled in the appropriate category. Notification of enrollment into TennCare Standard will include notification of the denial of TennCare Medicaid eligibility.

(iii) If HCFA determines that the enrollee is eligible for CoverKids, the agency will notify the enrollee and he will be enrolled into the CoverKids program. Notification of enrollment into CoverKids will include the denial of TennCare Medicaid eligibility.

7. If an enrollee provides some but not all of the necessary information to HCFA to determine his eligibility for open Medicaid categories or CoverKids during the forty (40) day period following the mailing of the renewal packet, HCFA will request additional information or verification. The request for additional information or verification will provide the enrollee with twenty (20) days, inclusive of mail time, to submit the requested information.

8. Enrollees who do not respond to the renewal packet within forty (40) days, or enrollees who do not respond to a request for additional information or verification within twenty (20) days from the request for additional information or verification, will be sent a notice of termination informing the enrollee that coverage will be terminated 20 days from the date of the termination notice.

9 If HCFA makes a determination that the enrollee is not eligible for any open Medicaid categories, TennCare Standard or CoverKids, the enrollee will be sent a notice of termination informing the enrollee that coverage will be terminated 20 days from the date of the termination notice.

10. Enrollees who respond to the additional information or verification request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare Medicaid, TennCare Standard or CoverKids while HCFA reviews their eligibility.

11. Individuals may provide the renewal packet, or additional information and verifications specified in the request for additional information and verification notice, up to 90 days after termination of eligibility. Renewal packets or additional information and verification received during the 90 day reconsideration period will be processed as required by 42 CFR § 435.916. Individuals terminated for failure to respond and subsequently determined eligible during the 90 day reconsideration period will have eligibility reinstated as of the date of termination.

12. Renewal packets returned after 90 days will be considered new applications and processed in accordance with 1200-13-20-.05.

(d) A woman who has been determined eligible for TennCare Medicaid under the rules for BCC shall annually recertify her eligibility in terms of continuation of active treatment, her address, and access to health insurance. If she is found to no longer be eligible through this review, the enrollee will be reviewed using the redetermination process set forth in this paragraph.

(2) Termination of TennCare Medicaid, TennCare Standard and CoverKids eligibility.

(a) HCFA will send termination notices to all enrollees being terminated pursuant to State and federal law who are not determined to be eligible for open Medicaid or TennCare Standard categories, or CoverKids.

(b) Termination notices will be sent twenty (20) days in advance of the date the coverage will be terminated. Termination notices will be sent two (2) days in advance of the date coverage will be prospectively terminated when an enrollee requests termination. Termination notices will be sent to the HCFA address of record.

(c) Termination notices will provide enrollees forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by HCFA in accordance with chapter 1200-13-19.

(d) Enrollees with a physical health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with limited English proficiency will have the opportunity to request translation assistance for their appeal.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 4/28/2016

Signature:

Name of Officer: Darin J. Gordon

Title of Officer: Directory, Bureau of TennCare
Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 4/28/16

Notary Public Signature: Kathy Crockarell

My commission expires on: 1/8/2019

KATHY CROCKARELL STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY

Department of State Use Only

Filed with the Department of State on: 4/28/16

Tre Hargett
Secretary of State

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