



# TennCare Operational Protocol

## Chapter 3: Benefits and Cost-Sharing

Section 3.1 Benefits
-------------------------

### 3.1.1 TennCare Benefits

The benefits available to TennCare enrollees are listed in the TennCare Rules and Regulations, for both TennCare Medicaid and TennCare Standard, available on the Bureau's website. Definitions of specific services and services that are excluded from coverage are also listed in the rules.

*Reference: See Rules 1200-13-13-.04 and 1200-13-14-.04 (Covered Services) and Rules 1200-13-13-.10 and 1200-13-14-.10 (Exclusions). TennCare benefits are also discussed at STC # 30.*

These rules should be consulted for information on particular limitations and coverage details.

TennCare benefits include, but are not limited to, the following:

- Community health services
- Dental services (for children under age 21)
- Durable medical equipment
- Emergency air and ground transportation services
- EPSDT services for TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21
- Home health care<sup>1</sup>
- Hospice care
- Inpatient and outpatient substance abuse treatment services
- Inpatient hospital services
- Lab & X-ray services
- Medical supplies
- Mental health case management
- Mental health crisis services
- Non-emergency transportation services
- Occupational therapy
- Organ and tissue transplant services and donor organ/tissue procurement services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy services

---

<sup>1</sup> Home health benefits are limited for adults as follows: Part-time or intermittent nursing services must be no more than 1 visit/day, lasting less than 8 hours, and no more than 27 total hours of nursing care per week. Part-time or intermittent nursing services are not covered if the only skilled nursing function is administration of medication on an as needed basis. Home health aide services must be provided at no more than 2 visits/day, with care provided less than or equal to 8 hours/day. Nursing services and home health aide services combined must total less than or equal to 8 hours/day and 35 of fewer hours per week. See TennCare Medicaid rule 1200-13-13-.01 and TennCare Standard rule 1200-13-14-.01.

- Physical therapy services
- Physician services
- Private duty nursing services<sup>2</sup>
- Psychiatric inpatient facility services
- Psychiatric rehabilitation services
- Reconstructive breast surgery
- Renal dialysis clinic services
- Speech therapy services
- Vision services (for children under age 21)

Additional benefits are covered for children under 21 as medically necessary.

The concept of medical necessity is an important factor in the coverage of services under TennCare. TennCare Rule 1200-13-16 outlines the criteria that must be met for a service to be considered “medically necessary.”

In addition to the above-listed services, there are other services that Managed Care Contractors may choose to offer as “cost effective alternatives.” These services are provided at the sole discretion of the MCCs when they believe that they can meet an enrollee’s needs appropriately by offering a service that is a lower-cost alternative to the service that is covered. Policy Statement BEN 08-001, located on the TennCare website, describes cost-effective alternatives in more detail.

Additional information about coverage arrangements is contained in TennCare policies found on the Bureau’s website. <http://www.state.tn.us/tenncare/pol-policies.html>,

*Reference: See STCs # 30 & # 31*

### **3.1.2 Benefits for Dual Eligibles**

Dual eligibles are Medicare beneficiaries who are also eligible for some form of assistance from TennCare. A list of the categories of dual eligibles, and a description of each category, is presented in Section 2.1.3.

The TennCare benefits to which dual eligibles are entitled are summarized in Table 3-1 below. Payments of Medicare premiums are made by the Bureau of TennCare through a “buy-in” agreement with CMS. Payment of deductibles and coinsurance is also made by the Bureau of TennCare. An MCC may choose to pay Medicare premiums and/or cost sharing for beneficiaries who are not entitled to these payments from TennCare if doing so would lower the payments required from the MCC.

---

<sup>2</sup> Private duty nursing services for adults are covered only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required.

**Table 3 - 1  
TennCare Benefits for Dual Eligibles**

<b>Categories of Dual Eligibility</b>	<b>Eligible for TennCare Services Not Covered by Medicare?</b>	<b>What TennCare Covers</b>
QMB	No	Medicare Part A and Part B premiums.  Deductibles and coinsurance for all Medicare services, regardless of whether or not these are covered by TennCare.
QMB Plus	Yes	Medicare Part A and Part B premiums.  Deductibles and coinsurance for all Medicare services, regardless of whether or not these are covered by TennCare.  All TennCare services not covered by Medicare.
SLMB	No	Medicare Part B premiums.
SLMB Plus	Yes	Medicare Part B premiums.  All TennCare services not covered by Medicare.  Deductibles and coinsurance for all Medicare services that are also covered by TennCare. No payments for Medicare coinsurance when the Medicare service is not covered by TennCare, unless the enrollee is under 21 or an SSI beneficiary.
QI	No	Medicare Part B premiums.
QDWI	No	Medicare Part A premiums.
Other Medicaid/Medicare Duals	Yes	Medicare Part B premiums, except Medically Needy.  Deductibles and coinsurance for all Medicare services that are also covered by TennCare. No payments for Medicare deductibles or coinsurance when the Medicare service is not covered by TennCare, unless the enrollee is under 21 or an SSI beneficiary.  All TennCare services not covered by Medicare.

**3.1.3 Benefits for TennCare CHOICES**

With the implementation of the CHOICES program, TennCare provides physical, behavioral and substance abuse, and long-term care benefits through its managed care delivery systems. The following table (3-2) lists the HCBS benefits for TennCare Medicaid enrollees and CHOICES Demonstration eligibles who are enrolled in the designated CHOICES groups.

These benefits are in addition to the benefits that are available to them through the regular TennCare program. The following rules also apply to the CHOICES benefit:

- The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in section 1915(c) waivers as set forth in section 1915(c)(4)(A) of the Social Security Act. The state may delegate the implementation of the cost-neutrality test to the MCOs.
- For purposes of determining capitation rates, the cost of room and board, as defined in the STCs, is not included in non-institutional care costs.
- Definitions for CHOICES benefits are found in Attachment D to the waiver STCs.

The CHOICES 1 category consists of those individuals who are receiving Medicaid-reimbursed care in a Nursing Facility (NF).

The CHOICES 2 category is for persons age 65 and older or adults age 21 and older with physical disabilities, who meet the NF level of care (LOC) criteria, who qualify as SSI recipients or as members of the 217-Like demonstration population<sup>3</sup>, and who need and are receiving HCBS as an alternative to NF care.

**Table 3-2  
Benefits for Persons Enrolled in the  
CHOICES Program**

Benefit	CHOICES 1	CHOICES 2
Nursing facility care	X	Short-term Only
Community-based residential alternatives		X
Personal care visits (up to 2 visits per day)		X
Attendant care (up to 1,080 hours per calendar year)		X
Homemaker services (up to 3 visits per week)		X
Home-delivered meals (up to 1 meal per day)		X
Personal Emergency Response Systems (PERS)		X
Adult day care (up to 2,080 hours per calendar year)		X
In-home respite care (up to 216 hours per calendar year)		X
In-patient respite care (up to 9 days per calendar year)		X
Assistive technology (up to \$900 per calendar year)		X

<sup>3</sup> “217-Like” refers to the CHOICES 217-Like HCBS Group, who will be enrolled in TennCare Standard, consisting of individuals aged 65 and older or individuals age 21 and older with physical disabilities who meet the nursing facility level of care criteria and who could have been eligible for HCBS had the state continued its 1915(c) HCBS waiver for the elderly and/or physically disabled. The “217” comes from 42 CFR 435.217 which refers to eligibility for an HCBS waiver. See STC # 21.

Benefit	CHOICES 1	CHOICES 2
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X
Pest Control (up to 9 units per calendar year)		X

See STC # 30h

<p>Section 3.2 TennCare Cost-Sharing</p>
----------------------------------------------

**Premiums.** There are no premiums charged in the TennCare program.

**Deductibles.** There are no deductibles charged in the TennCare program.

**Copays.** Certain enrollees have copay obligations on selected services. Most of these copays are calculated based on the enrollee’s income information, which is collected by the Department of Human Services when the enrollee applies for TennCare. Enrollees must report any changes in income to their DHS caseworkers at the time such change occurs. Enrollees must provide a completed employer statement showing the new income. Self-employed enrollees must provide appropriate proof of income changes, such as the most recent quarterly tax statement filed with the IRS. Information about documentation to be supplied and the reporting of changes to enrollee information is provided in *Tennessee Code Annotated (T.C.A.) 71-5-110*.

Copays are collected by the provider at the time of service. However, providers are prohibited from denying TennCare-covered services to enrollees who are unable or fail to pay the required copay.

Additional information about enrollee cost sharing can be found in Sections 3.2.1 and 3.2.2. below and in TennCare’s rules.

*Reference: See Rules 1200-13-13-.05 and 1200-13-14-.05 and STC # 35.*

### 3.2.1 Pharmacy Copays

The pharmacy copay applies to the following populations:

- All TennCare adults, aged 21 and older, except for the following:
  - Adults who are being served in Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, or Home and Community-Based Services waivers
  - Adults who are getting prescriptions for family planning drugs or supplies
  - Adults who are receiving emergency services
  - Adults who are pregnant
  - Adults who are receiving hospice services

- All TennCare Standard adults who are enrolled in the SSD program<sup>4</sup>
- All TennCare Standard children with incomes at or above 100% of poverty

The pharmacy copay is \$3.00 for brand-name drugs. There is no pharmacy copay required for generic drugs.

### 3.2.2 Non-Pharmacy Copays

Non-pharmacy copays apply to the following populations:

- All TennCare Standard enrollees with incomes at or above 100% of poverty, except for those in the SSD program and those in the CHOICES 217-Like group.

**Table 3 – 3  
Current TennCare Copay Schedule**

	<b>Income Level of 100% to 199% of Poverty</b>	<b>Income Level of 200% of Poverty and above</b>
Hospital emergency room service (waived if admitted)	\$25	\$50
Primary care provider services other than preventive care	\$5	\$10
Community Mental Health Agency services other than preventive care	\$5	\$10
Physician specialists (including psychiatrists)	\$15	\$25
Inpatient hospital admissions	\$100	\$200

### 3.2.4 TennCare and Third Party Insurance

Some TennCare Medicaid enrollees have other health insurance along with their TennCare coverage. This occurs most often when an enrollee has a job with insurance, but their overall circumstances still qualifies them for TennCare Medicaid. Sometimes an enrollee may have purchased a policy on his own. Attachment B is a listing of what is and what is not considered to be health insurance under TennCare. TennCare is always the payer of last resort, except in a few circumstances where federal law states otherwise.

When an enrollee has third party liability (TPL), that third party must be billed before submitting the bill to the enrollee's TennCare MCO. Providers must follow the third party's requirements for obtaining payment (i.e., getting prior authorization) in addition to the requirements for submitting claims to the MCO.

*Reference:*

---

<sup>4</sup> TennCare Standard adults in the Discontinued Demonstration Group (see Section 2.1.2) do not have a pharmacy benefit.

CON 05-001 “MCCs’ and Providers’ Responsibility When Enrollees has Third Party Copays and/or Deductibles.” <http://www.tn.gov/tenncare/forms/con05001.pdf>

### **3.2.5 Seeking Payment from a TennCare Enrollee**

As a general rule of thumb, applicable copayments as described in the previous sections are the only payments that providers can accept from TennCare enrollees. One of the conditions of participation in TennCare for providers is that they accept the payment amounts that they receive from the MCCs as payment in full.

There are only two circumstances when providers can seek payment, other than copays, from a TennCare enrollee. One is when the service requested is not covered by TennCare and the provider informed the enrollee, prior to providing the service, that it is not covered. The other is when the service requested, such as a sixth prescription within a month's time, exceeds an established benefit limit. The procedures to be followed in either of these circumstances are outlined in TennCare Rule 1200-13-13-.08(5) and 1200-13-14-.08(5).

TennCare rules 1200-13-13-.08(6) and 1200-13-14-.08(6) outline the circumstances when providers cannot seek payment from a TennCare enrollee.

*Reference: See Rules 1200-13-13-.08(5) & (6) and 1200-13-14-.08(5) & (6).*

*Policy Statement: PRO 08-001 – Seeking Payment from a TennCare Enrollee*  
<http://www.tn.gov/tenncare/forms/pro08001.pdf>