**RULES**
**OF**
**THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**
**DIVISION 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 will refer to the programs collectively as TennCare, unless a specific process or requirement for TennCare Medicaid, TennCare Standard, the Medicare Savings Program, or CoverKids differs from the general TennCare process or requirement. This Chapter preempts any other TennCare 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 C.F.R. Parts 431 and 435 require the designated State agency to provide for eligibility determinations for applicants seeking assistance and services provided through the programs.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019.*

**1200-13-20-.02 DEFINITIONS AND ACRONYMS.**

(1) Access to Health Insurance (TennCare). The opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an employer's or group's open enrollment period and chose not to enroll (or had the choice made for him by a family member) that person shall not be considered to lack access to insurance upon closure of the open enrollment period. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the TennCare Program shall be considered in determining eligibility to enroll in any TennCare category where being uninsured is an eligibility prerequisite. Access to health insurance through the Federally

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Facilitated Marketplace (FFM) shall not constitute "access to insurance" for purposes of eligibility for TennCare.

(2) Achieving a Better Life Experience (ABLE) Account. An account established under 26 U.S.C.A. § 529A. ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program.

(3) Active SSI Recipient. An individual who has been found eligible to receive SSI benefits by the SSA.

(4) Aged. An individual age sixty-five (65) or older.

(5) 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.

(6) 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.

(7) 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).

(8) Application. The single, streamlined form developed for use for all insurance affordability programs, as required by 42 C.F.R. § 435.907(b).

(9) Application File Date. See Rule .05(5).

(10) At-Risk for Institutionalization. See definition in Rule 1200-13-01-.02.

(11) Authorized Representative. An Authorized Representative as defined at 42 C.F.R. § 435.923.

(12) Blind. An individual who is determined to be blind by the SSA or who has been determined to be blind by the Division of TennCare according to 42 C.F.R. §§ 435.530 and 435.531.

(13) Breast and Cervical Cancer (BCC). 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 sixty-five (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.

(14) Bureau of TennCare (Bureau). The agency within the Division of TennCare which directly administers the TennCare program.

(15) 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:

(Rule 1200-13-20-.02, continued)

(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.

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

(17) Child Support Enforcement. The enforcement of the child support program in the State of Tennessee by the Tennessee Department of Human Services Child Support Services Division under Title IV-D of the Social Security Act, as established by relevant state and federal statutes, and as outlined in Chapter 1240-02-04.01.

(18) Child Tax Credit Payment(s). A type of Federal Income tax refund (including any advance payments) that is excluded as a resource for a period of twelve (12) months following receipt.

(19) Children's Health Insurance Program (CHIP). Established by Title XXI of the Social Security Act and administratively included in the Division of TennCare.

(20) CHOICES. TennCare CHOICES in Long-Term Services and Supports, as defined in Rule 1200-13-01-.02.

(21) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.

(22) CHOICES At-Risk Demonstration Group. See definition in Rule 1200-13-01-.02.

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

(24) 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, Medicare Savings Program or CoverKids eligibility, including technical and financial requirements as set out in this Chapter; and

(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.

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

(26) Continued Eligibility Group Part C. See definition in Rule 1200-13-01-.02.

(27) Continuous Eligibility. The period in which an enrollee's coverage will not be terminated, regardless of changes in the enrollee's circumstances. See Rule .09 for applicability and exceptions.

(28) 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

(Rule 1200-13-20-.02, continued)

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.

(29) CoverKids. The Children's Health Insurance Program (CHIP) in Tennessee under T.C.A. § 71-3-1101.

(30) CoverKids Pregnant Women (formerly referred to as "CoverKids Pregnant Women/Unborn Children"). Provides coverage for the unborn children of Pregnant Women with no source of coverage, who meet the CoverKids eligibility requirements.

(31) 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 C.F.R. § 435.117. A child is eligible for Medicaid in this category from birth until the child's first birthday without application if, on the date of the child's birth, the child's mother was eligible for and received covered Medicaid services.

(32) Developmental Disability(ies) (DD). See definition in Rule 1200-13-01-.02.

(33) Disabled. An individual who has been determined to be disabled by the SSA or who has been determined to be disabled by the Division of TennCare according to 42 C.F.R. §§ 435.540 and 435.541.

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

(35) Division of TennCare. The Agency established within the Department of Finance and Administration to consolidate and administratively coordinate multiple health care programs, including the Bureau of TennCare and CoverKids.

(36) Earned Income. Earned income is compensation an individual receives for the performance of services or as a result of his own efforts either as an employee or through self-employment.

(37) ECF CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.

(38) ECF CHOICES At-Risk Group. Individuals with I/DD who are otherwise ineligible for TennCare Medicaid or who are eligible in a TennCare Medicaid category that does not confer LTSS benefits, do not meet the Nursing Facility Level of Care (NF LOC) criteria, but who in the absence of ECF CHOICES, are At Risk for Institutionalization, have income at or below one hundred and fifty percent (150%) of the FPL and meet the resource limit for the ECF CHOICES 217-Like Group.

(39) ECF CHOICES Demonstration Group. One of the TennCare Demonstration categories that individuals with I/DD, who are not active SSI enrollees, must be enrolled in to qualify for Employment and Community First CHOICES. These groups include the ECF CHOICES 217-Like Group, the Interim ECF CHOICES At-Risk Group, the ECF CHOICES At-Risk Group, and the ECF CHOICES Working Disabled Group.

(40) ECF CHOICES Working Disabled Group. Working individuals with I/DD who meet the Nursing Facility Level of Care (NF LOC) criteria, or who in the absence of ECF CHOICES, are at risk for institutionalization, would be eligible for SSI but for their earned income, have income at or below two hundred and fifty percent (250%) of the FPL meet the resource limit for the ECF CHOICES 217-Like Group, and who are not otherwise eligible in a TennCare Medicaid category that confers LTSS benefits. Enrollment in this group shall be subject to the

(Rule 1200-13-20-.02, continued)

enrollment targets established for each applicable ECF CHOICES benefit group as specified in TennCare Rule 1200-13-01-.31.

(41) Economic-Impact Payments. Economic-Impact Payments received as direct payments from an agency of the federal government during the COVID-19 federal public health emergency.

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

(43) Eligible. An individual who has been determined to meet the eligibility criteria for medical assistance under Tennessee's State Plan or in any Tennessee federal Medicaid waiver program approved by the Secretary of the HHS pursuant to Sections 1115 or 1915 of the Social Security Act or in the CoverKids program. (42 U.S.C. §§ 1315 or 1396n).

(44) Employment and Community First CHOICES (ECF CHOICES). See definition in Rule 1200-13-01-.02.

(45) 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 HHS pursuant to Sections 1115 or 1915 of the Social Security Act or in the CoverKids program. (42 U.S.C. §§ 1315 or 1396n). For purposes of this Chapter, enrollee also includes individuals eligible for and enrolled in the Medicare Savings Programs (MSPs).

(46) Enrollment. The process by which a TennCare, CoverKids, or Medicare Savings Program eligible individual becomes enrolled in TennCare, CoverKids or a Medicare Savings Program.

(47) Estranged Spouse. A spouse who no longer shares a residence with the applicant, whose whereabouts are unknown and who cannot be contacted despite attempts to do so.

(48) Exchange. A governmental agency or non-profit entity that meets the applicable Federal standards and makes Qualified Health Plans (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 HHS.

(49) Extended Medicaid. Medicaid eligibility authorized for enrollees who lose Child Modified Adjusted Gross Income (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 three (3) of the six (6) months preceding the month of the increase in income.

(50) Families First (FF). Tennessee's Temporary Assistance for Needy Families (TANF) program.

(51) 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.

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

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

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

(Rule 1200-13-20-.02, continued)

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

(56) 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)). For purposes of the Medicaid eligibility category Former Foster Care Children Under 26, "state" means any of the 50 U.S. states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(57) 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 an 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.

(58) Health Insurance (for CoverKids).

(a) Health insurance, for purposes of determining eligibility for CoverKids under this Chapter, shall mean:

1. Basic medical coverage (hospitalization plans);

2. Major medical insurance;

3. Comprehensive medical insurance;

4. Short-term medical policies;

5. Mini-medical plans;

6. High-deductible plans with health savings accounts; or

7. Other coverage including Medicare, TennCare, TRICARE, and employer-sponsored coverage.

(b) Health insurance, for purposes of determining eligibility for CoverKids under this Chapter, shall not include the following:

1. AccessTN;

2. Catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of $3,000.00 (or the maximum allowed deductible for a health savings account plan);

3. Dental-only plans;

4. Vision-only plans;

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

(Rule 1200-13-20-.02, continued)

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

7. Medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (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 C.F.R. §§ 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 C.F.R. § 457.310(c)(1)(ii)) to the premium for the dependent, who is applying (or re-applying) for coverage through CoverKids.

(59) Health Insurance (for TennCare).

(a) Health insurance, for purposes of determining eligibility for TennCare under this Chapter, 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 (HMO) 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 individual or all members of a family under a single policy where the contract exists solely between the individual and the insurance company;

12. Policies listed in parts 1. through 11. which include any of the following are health insurance:

(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; or

(Rule 1200-13-20-.02, continued)

(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 this subparagraph 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 this Rule;

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.

(60) Health Insurance Marketplace, also referred to as the “Marketplace”, “Exchange” or “Federally Facilitated Marketplace.” See “Exchange.”

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

(Rule 1200-13-20-.02, continued)

(62) Hospital Presumptive Eligibility (HPE). Medicaid eligibility determined pursuant to 42 C.F.R. § 435.1110.

(63) Household Size. The number of individuals counted as members of an individual's household for purposes of determining eligibility for TennCare.

(64) 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.

(65) 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.

(66) Incarcerated. The state of being involuntarily 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.

(67) Incurred Medical Expense. The term used in Tennessee to refer to the methodology for deducting expenses incurred for necessary medical or remedial care for institutionalized individuals in the post-eligibility phase of income. Previously known as "Item D." See 42 C.F.R. §§ 435.725(c)(4), 435.726(c)(4) and 435.832(c)(4).

(68) 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), (VI) and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX); and 1396u-1(b) and (d)).

(69) Institutional Eligibility. The eligibility category defined at Section 1902(a)(10)(A)(ii)(V), (VI) and (VII) of the Social Security Act. (42 U.S.C. § 1396a(a)(10)(A)(ii)(V), (VI) and (VII)), including the CHOICES 217-Like Group, CHOICES At-Risk Demonstration Group, and the Program of All-Inclusive Care for the Elderly (PACE) where Enrollees qualify for eligibility under institutional income and resource rules.

(70) Institutional Spouse. An institutionalized individual who is the legal spouse of a Community Spouse.

(71) 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.

(72) Intellectual Disability(ies) (ID). See definition in Rule 1200-13-01-.02.

(73) Intellectual or Developmental Disability(ies) (I/DD). See definition in Rule 1200-13-01-.01(4)(v).

(74) Interim ECF CHOICES At-Risk Group. See definition in Rule 1200-13-01-.02.

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

(Rule 1200-13-20-.02, continued)

(76) 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.

(77) Katie Beckett Group Part A. See definition in Rule 1200-13-01-.02.

(78) Katie Beckett Program. See definition in Rule 1200-13-01-.02.

(79) Level of Care (LOC). See definition in Rule1200-13-01-.02.

(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) Marketplace. See "Exchange."

(84) Medicaid. The federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act. Medicaid eligibility in Tennessee is determined by TennCare. Tennessee residents determined eligible for SSI benefits by the Social Security Administration are also enrolled in Tennessee's TennCare Medicaid program.

(85) Medicaid Diversion Group Part B. See definition in Rule 1200-13-01-.02.

(86) Medicaid Income Cap (MIC). Three hundred percent (300%) of the SSI Federal Benefit Rate.

(87) 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 according to the provisions of these Rules.

(88) Medical Assistance. All categories for which TennCare is authorized to make an eligibility determination, including Medicaid and MSP categories, CHIP, and categories granted under TennCare's Demonstration Agreement with CMS.

(89) Medical Institution. See definition at 42 C.F.R. § 435.1010.

(90) 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)).

(91) Medically Needy Income Standard (MNIS). See definition at 42 C.F.R. § 435.811.

(92) 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), as determined by the SSA.

(93) 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, or coinsurance.

(94) 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 or coinsurance. These programs include the Qualified Medicare

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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.

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

(96) Modified Adjusted Gross Income (MAGI). See definition at 42 C.F.R. § 435.603(e).

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

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

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

(100) Payment for Emergency Medical Services. Eligibility authorized by Section 1903(v) of the Social Security Act (42 U.S.C. § 1396b(v)).

(101) Personal Needs Allowance (PNA). A reasonable amount of money that is deducted by TennCare from the individual's funds pursuant to federal and State law and the Medicaid State Plan in the application of post-eligibility provisions and the calculation of Patient Liability for LTSS. The PNA is set aside for clothing and other personal needs of the individual while in the institution (Institutional PNA), and to also pay room, board and other living expenses in the community (Community PNA).

(102) Pickle Passalong. The eligibility category defined at 42 C.F.R. § 435.135.

(103) Pregnant Woman (also Pregnant Women). See definition at 42 C.F.R. § 435.4.

(104) TennCare Pregnant Women. For purposes of this Chapter, the Medicaid eligibility category defined at Sections 1902(a)(10)(A)(i)(III), (IV) and (VII); 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)(I), (IV) and (IX); and 1396u-1(b) and (d)); and 42 C.F.R. § 435.116. For purposes of this Chapter, TennCare Pregnant Women also includes Pregnant Women determined eligible under Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(A)(ii)(XX)) and 42 C.F.R. § 435.218.

(105) 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.

(106) Presumptive Eligibility for Pregnant Women. Pregnant Women presumed to be eligible for coverage in the category defined at Sections 1902(a)(10)(A)(i)(III), (IV) and (VII); 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)(I), (IV) and (IX); and 1396u-1(b) and (d)); and in 42 C.F.R. § 435.1103 by the Tennessee Department of Health or other qualified entity. For purposes of this Chapter, Presumptive Eligibility for Pregnant Women also includes Pregnant Women determined eligible under Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(A)(ii)(XX)) and 42 C.F.R. § 435.218.

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

(108) 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

(Rule 1200-13-20-.02, continued)

two hundred percent (200%) of the FPL 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) and (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)).

(109) Qualified Health Plan (QHP). See definition at 42 U.S.C. § 18021.

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

(111) Qualified Long-Term Care Insurance Partnership Policy (LTCP). 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 that State and the State of Tennessee.

(112) Qualified Lottery Winnings. Monetary winnings from a sweepstakes, lottery, or pool received as a lump sum payment on or after January 1, 2018, in accordance with § 1902(e)(14)(K) of the Social Security Act.

(113) Qualified Lump Sum Income. Income that is received as a lump sum from monetary winnings from gambling received on or after January 1, 2018, in accordance with § 1902(e)(14)(K) of the Social Security Act.

(114) Qualified Medicare Beneficiary (QMB). An individual who is entitled to 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 FPL. 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)).

(115) Qualifying Individual 1 (QI1). An individual who is entitled to 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 FPL but less than one hundred and thirty-five percent (135%) of the FPL. 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.

(116) Qualifying Medical Condition. A medical condition included on a list of conditions established by TennCare which will render a qualified uninsured applicant medically eligible.

(117) 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, CoverKids, Katie Beckett Group Part A, Medicaid Diversion Group Part B, and Continued Eligibility Group Part C enrollees. This is a periodic process that is conducted at specified intervals. The process is conducted according to TennCare's, or its designee's, policies and procedures and is also referred to as "Renewal." The Medicaid Diversion Group Part B, including redetermination of eligibility, will be administered by the Department of Intellectual and Developmental Disabilities (DIDD).

(118) Renewal. See "Redetermination."

(Rule 1200-13-20-.02, continued)

(119) 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.

(120) Retroactive Eligibility. Eligibility granted prior to the Application File Date according to 42 C.F.R. 435.915 and TennCare's 1115 Demonstration Waiver. Retroactive Eligibility is only available to individuals for which the requirement at 42 U.S.C. 1396a(a)(34) has not been waived under TennCare's 1115 Demonstration Waiver.

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

(122) Specified Low-Income Medicare Beneficiary (SLMB). An individual 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%) but less than one hundred twenty percent (120%) of the FPL. 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)).

(123) Spenddown. The process by which excess income is utilized for recognized medical expenses until it is depleted, which results in a determination of eligibility if all other eligibility factors are met for the Medically Needy categories.

(124) SSI Federal Benefit Rate. The maximum dollar amount paid to an aged, blind, or disabled person who receives Social Security Disability Benefits under Supplemental Security Income (SSI).

(125) 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/Widower.

(126) 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 is two hundred and eleven percent (211%) of the FPL or higher, who does not have access to health insurance, and who has been determined medically eligible according to these Rules.

(127) Standard Child Uninsured. The TennCare Demonstration category defined as including individuals 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 below two hundred and eleven percent (211%) of the FPL, 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 below two hundred and eleven percent (211%) of the FPL, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. When an individual loses eligibility in this category, he will not be able to re-enroll in it.

(Rule 1200-13-20-.02, continued)

(128) Student. A child under age twenty-one (21), unless otherwise specified in this Chapter, who is:

(a) Eligible for and attending grades kindergarten through twelve at a State-approved elementary or secondary school, or a course of vocational or technical training, or equivalent instruction from a homebound teacher; or

(b) Eligible for and attending a college or university.

1. Full-time student means enrollment in at least twelve (12) credit hours per semester.

2. Part-time student means enrollment in at least six (6) but less than twelve (12) credit hours per semester.

(c) Student status is retained during official school vacations and breaks if the conditions or requirements prior to the vacation or break were met, and the student plans to return after the break.

(d) Regularly attending school, except when circumstances beyond the student's control justify a reduced credit load or attendance, means:

1. College or university, at least 8 hours per week (semester or quarter system);

2. Grades 7–12, including home-schooled, at least 12 hours per week;

3. Training course preparing for a paying job, at least 12 hours per week or 15 hours per week if the course involves shop practice; or

4. Homebound courses given by a school grades 7–12, college, university or government agency when the student must stay home due to a disability and has a home visitor or tutor from school who directs the studying or training.

(e) Individuals participating in apprenticeships, correspondence courses, other courses of home study and rehabilitation programs other than academic, institutional, vocational or technical training are excluded from this definition of student for purposes of this Chapter.

(129) 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.).

(130) 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.

(131) 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; also, the name of the Division within the Department of Finance and Administration which includes the Bureau of TennCare and CoverKids; and, the name of the Bureau which directly administers the program.

(132) 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

(Rule 1200-13-20-.02, continued)

eligible in the Institutional Medicaid category or who are active SSI enrollees and who meet the requirements of the program set out in Chapter 1200-13-01.

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

(a) Tennessee residents determined to be eligible for Medicaid according to 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 and TennCare Medicaid by the SSA are automatically enrolled in TennCare Medicaid.

(134) 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.

(135) Termination. The discontinuance of an enrollee's coverage under the Medical Assistance programs.

(136) 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 U.S.C. § 1396a(a)(10)(A)(i)(I)), 42 C.F.R. § 435.115, and 42 C.F.R. § 435.145.

(137) Transitional Medicaid. Medicaid authorized for enrollees who lose Child 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 three (3) of the six (6) months immediately preceding the month eligibility is lost.

(138) Uninsured. Any individual who does not have health insurance directly or indirectly through another family member, or who does not have access to group health insurance. For purposes of the Medicaid eligibility category of women under age 65 requiring treatment for breast or cervical cancer, "uninsured" shall mean any individual who does not have health insurance or access to health insurance which covers treatment of breast or cervical cancer.

(139) Valid Application. The single streamlined application form for all insurance affordability programs. It must include contact information and be signed by the Applicant, a Responsible Party, or the Authorized Representative.

(140) Widow/Widower. The eligibility category defined at 42 C.F.R. § 435.138.

(141) ACRONYMS. Following is a list of the acronyms used in this Chapter.

(a) ABD – Aged, Blind or Disabled

(b) AFDC – Aid to Families with Dependent Children

(Rule 1200-13-20-.02, continued)

(c) APTC – Advanced Premium Tax Credit

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

(e) BCC – Breast and Cervical Cancer

(f) BCSP – Breast and Cervical Screening Program

(g) CCRC – Continuing Care Retirement Community

(h) CHIP – Children's Health Insurance Program

(i) CHOICES – TennCare CHOICES in Long-Term Care

(j) CMS – Centers for Medicare & Medicaid Services

(k) COLA – Social Security Cost-of-Living Adjustment

(l) CSIMA – Community Spouse Income Maintenance Allowance

(m) CSRMA – Community Spouse Resource Maintenance Allowance

(n) DAC – Disabled Adult Child

(o) DCS – Department of Children's Services

(p) DIMA – Dependent Income Maintenance Allowance

(q) ECF CHOICES – Employment and Community First CHOICES

(r) FEMA – Federal Emergency Management Agency

(s) FF – Families First

(t) FFM – Federally Facilitated Marketplace

(u) FFP – Federal Financial Participation

(v) FPL – Federal Poverty Level

(w) FRR – Financially Responsible Relatives

(x) HCBS – Home and Community Based Services

(y) HHS – United States Department of Health and Human Services

(z) HPE – Hospital Presumptive Eligibility

(aa) I/DD – Intellectual or Developmental Disability(ies)

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

(cc) IRA – Individual Retirement Account

(dd) LTCP – Qualified Long-Term Care Insurance Partnership Policy

(Rule 1200-13-20-.02, continued)

(ee) LTSS – Long-Term Services and Supports

(ff) MAGI – Modified Adjusted Gross Income

(gg) MIC – Medicaid Income Cap

(hh) MNIS – Medically Needy Income Standard

(ii) MSP – Medicare Savings Program

(jj) OASDI – Old-Age, Survivors, and Disability Insurance (Social Security Benefits)

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

(ll) PASS – Plan to Achieve Self Support

(mm) PNA – Personal Needs Allowance

(nn) QDWI – Qualified Disabled and Working Individual

(oo) QHP – Qualified Health Plan

(pp) QIT – Qualified Income Trust

(qq) QI1 – Qualifying Individual

(rr) QMB – Qualified Medicare Beneficiary

(ss) SLMB – Specified Low Income Medicare Beneficiary

(tt) SSA – Social Security Administration

(uu) SSI – Supplemental Security Income

(vv) TANF – Temporary Assistance for Needy Families

(ww) VISTA – Volunteers in Service to America

(xx) WIOA – Workforce Innovation and Opportunity Act

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-117, 71-5-134, and 71-5-164; TennCare II/III Section 1115(a) Medicaid Demonstration Waiver Extension; and TennCare III Section 1115(a) Medicaid Demonstration Waiver.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019. Emergency rules filed November 20, 2020; effective through May 19, 2021. Amendments filed February 17, 2021; effective May 18, 2021. Amendments filed May 13, 2022; effective August 11, 2022. Amendments filed August 25, 2025; effective November 23, 2025.*

**1200-13-20-.03 DELINEATION OF ROLES AND RESPONSIBILITIES**.

(1) Agencies' Roles and Responsibilities.

(a) TennCare is responsible for determining eligibility for TennCare Medical Assistance and for conducting appeals of eligibility-related decisions, unless otherwise agreed to by the Single State Agency and CMS. TennCare is also responsible for coordinating

(Rule 1200-13-20-.03, continued)

the eligibility process for Medicaid and CHIP with the eligibility process for APTC/CSR in the FFM, in compliance with 42 C.F.R. §§ 435.1200 and 1205, unless otherwise agreed to by the Single State Agency and CMS.

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

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

(d) The Tennessee Department of Health (DOH) is responsible for conducting presumptive eligibility determinations for Pregnant Women and individuals in the BCC category.

(e) Approved Qualified Hospital Presumptive Eligibility (HPE) Entities are responsible for conducting presumptive eligibility determinations for Former Foster Care, Child MAGI, Caretaker Relative MAGI and Pregnancy MAGI categories.

(f) Approved Qualified Entities who are cancer detection and treatment providers are responsible for conducting presumptive eligibility determinations for individuals in the BCC category.

(g) The SSA is responsible for determining eligibility for receipt of benefits from the SSI program and for determining TennCare Medicaid eligibility for individuals who are eligible for SSI benefits. 42 U.S.C. § 1383c(a). Individuals determined eligible for SSI benefits and TennCare Medicaid by SSA are automatically enrolled in TennCare Medicaid.

(h) The FFM is responsible for making TennCare Medicaid and CoverKids eligibility assessments 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 applications to the State for full review.

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

(2) Enrollee Roles and Responsibilities.

(a) Each enrollee is responsible for reporting to TennCare any material change in the information affecting eligibility. This information includes, but is not limited to, changes in address, income, household size, employment, or access to insurance. The applicant/enrollee may submit those changes and any required documentation of changes to TennCare via phone, mail, fax, in person, or electronically through TennCare's online portal. Changes must be reported within ten (10) days of the occurrence.

(b) All verifications must be furnished within twenty (20) days of the notice requesting additional information unless otherwise specified by federal law.

(c) Each TennCare enrollee is responsible for reporting to his provider that he is a TennCare 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

(Rule 1200-13-20-.03, continued)

third party sources of medical support or benefits. Individuals applying as Caretaker Relatives under Medicaid (see Rule .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.

(e) Upon receipt of a notification of the beginning date of eligibility, each enrollee is responsible for complying with the instructions contained in the notice for submitting requests for reimbursement of costs of covered services incurred during the period of eligibility within sixty (60) days of the date of the notification.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-117, and 71-5-134.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019. Amendments filed August 25, 2025; effective November 23, 2025.*

**1200-13-20-.04 TECHNICAL ELIGIBILITY REQUIREMENTS.**

(1) State Residency. Individuals enrolled in TennCare must meet the requirements for State residency established in 42 C.F.R. § 435.403. Individuals applying for CoverKids must also meet the requirements specified at 42 C.F.R. § 457.320.

(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 with an anticipated date of return. The Bureau will assess the continuation of an individual’s temporary absence status on the 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 eighteen (18) to twenty-two (22) are not considered residents of the state if:

(i) Neither parent lives in the state;

(ii) The student is claimed as a tax dependent by someone in another state; and

(iii) The student is applying on his own behalf.

(Rule 1200-13-20-.04, continued)

(2) Citizenship. Individuals enrolled in TennCare must meet the requirements for citizenship or qualified non-citizen status established in 42 C.F.R. § 435.406 and in Tennessee's Citizenship and Non-Citizen Eligibility State Plan Amendment. 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) Individuals enrolled in TennCare must meet the SSN requirements of 42 C.F.R. § 435.910.

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

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

(4) Incarceration. Individuals 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. Individuals in a suspended status will be eligible for TennCare payments only for medical institution stays longer than twenty-four (24) hours. All other medical payments while in the suspended status are not subject to TennCare reimbursement. The suspended status will be removed once TennCare receives notice that the enrollee is no longer incarcerated. See also 42 C.F.R. § 435.1010.

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

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019.*

**1200-13-20-.05 GENERAL APPLICATION REQUIREMENTS.**

(1) Right to apply.

(a) Any individual shall have the opportunity to apply for Medical Assistance without delay.

(b) Information about the TennCare or CoverKids program shall be provided to any individual requesting it pursuant to 42 C.F.R. § 435.905.

(c) Applications may be filed by the applicant, an individual listed in Rule .05(3)(b), his Authorized Representative or someone acting responsibly for him. See 42 C.F.R. § 435.923.

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

(e) The right to file an application shall not be denied to any individual even if it is apparent that eligibility for Medical Assistance does not exist.

(Rule 1200-13-20-.05, continued)

(2) Rights and responsibilities.

(a) By applying for Medical Assistance, 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 Medical Assistance 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 C.F.R. § 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 Medical Assistance under false means or to help anyone obtain Medical Assistance under false means.

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

(3) Submitting an application.

(a) TennCare will accept Valid Applications in compliance with 42 C.F.R. § 435.907 and, for CoverKids applicants, 42 C.F.R. § 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 C.F.R. § 435.603(f);

2. An adult who is in the applicant's family, as defined in the Internal Revenue Code at 26 U.S.C. § 36B(d)(1);

3. Applicants over age fourteen (14) but under age eighteen (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;

(Rule 1200-13-20-.05, continued)

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;

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

9. A representative of the long term care facility where the individual resides.

(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 individuals residing in another state and not intending to reside in Tennessee will be denied.

2. Individuals who are in Tennessee for a temporary purpose, such as a visit, and 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. TennCare 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 application or other TennCare form completion;

(b) Help with 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. Paper applications mailed to TennCare. The Application File Date for an application mailed to TennCare will be the date a Valid Application is received.

2. Paper applications mailed to the FFM. The Application File Date will be the date provided by the FFM.

(b) By phone.

(Rule 1200-13-20-.05, continued)

1. Applicants may call TennCare to complete an application by phone. The Application File Date will be the date a Valid Application is completed telephonically.

2. The Application File Date for applications completed by phone through the FFM will be the date provided by the FFM.

(c) By fax. Paper applications may be faxed to TennCare. The Application File Date for applications faxed to TennCare will be the date a Valid Application is received.

(d) By online submission.

1. Applications may be submitted through TennCare's online portal. The Application File Date will be the date a Valid Application is submitted.

2. The Application File Date for applications filed through the FFM will be the date provided by the FFM, unless documentary evidence of an earlier application date exists.

(e) In person at any DHS county office.

1. The Application File Date for paper applications submitted to DHS will be the date of receipt of a Valid Application at DHS.

2. Applicants may use kiosks provided at DHS to submit online applications. Applicants may use phones provided at DHS offices to complete an application.

(f) Low Income Subsidy (LIS) applications through the SSA. The Application File Date will be the date provided by the SSA.

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

(7) Retroactive Eligibility. TennCare will grant Retroactive Eligibility with Valid Applications for Pregnant Women or children under age nineteen (19) as described in Section 1902(l)(4) of the Social Security Act (42 U.S.C.§ 1396a(l)(4)) who meet the retroactive eligibility requirements described in 42 C.F.R. § 435.915.

(8) Disposition.

(a) Eligibility is determined based on information contained on the Valid Application 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 an 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.

(Rule 1200-13-20-.05, continued)

(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, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-117, and 71-5-134.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019. Amendments filed May 13, 2022; effective August 11, 2022. Amendments filed August 25, 2025; effective November 23, 2025.*

**1200-13-20-.06 FINANCIAL ELIGIBILITY DETERMINATIONS.**

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

(a) All applicants for TennCare will have their income calculated for eligibility purposes according to the MAGI-based requirements at 42 C.F.R. § 435.603. The only exceptions are the Medicaid applicants at 42 C.F.R. §§ 435.603(j)(1)–(6).

1. Qualified Lottery Winnings and Qualified Lump Sum Income are counted as income for the individual who received such winnings or income:

(i) In the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

(ii) In equal monthly installments over a period of two (2) months if the amount of such winnings or income (as applicable) is greater than or equal to $80,000 but less than $90,000;

(iii) In equal monthly installments over a period of three (3) months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and

(iv) In equal monthly installments over a period of three (3) months plus one (1) additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

2. Hardship Exemption. If an individual's Qualified Lottery Winnings or Qualified Lump Sum Income causes them to exceed the MAGI income limit, the individual will continue to be eligible for MAGI coverage if TennCare determines that the denial of eligibility would cause an undue medical or financial hardship for the individual.

3. Qualified Lottery Winnings and Qualified Lump Sum Income are counted as income for other household members in the month received.

4. Any other monetary gambling winnings, including lottery winnings, that are not Qualified Lottery Winnings or Qualified Lump Sum Income are counted as income in the month received.

(Rule 1200-13-20-.06, continued)

(b) In compliance with 42 C.F.R. § 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 compliance with 42 C.F.R. § 435.603(g)(2), there are no income or expense disregards for individuals whose eligibility is determined according to MAGI requirements, with the exception of those described at 42 C.F.R. §§ 435.603(d)(1) through (4).

(e) Household composition, for financial eligibility determination purposes, for Child MAGI, Pregnancy MAGI, Caretaker Relative MAGI, TennCare Standard Uninsured, TennCare Standard Medically Eligible, and CoverKids categories will be determined using the MAGI methodology in accordance with 42 C.F.R. § 435.603(f). Household composition for all other categories will be determined according to 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 Medical Assistance, 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) For married couples who expect to file joint taxes but live separately, each spouse will be included in the other spouse’s household.

(v) 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 nineteen (19), or twenty-one (21) if a full-time student, and is claimed as a tax dependent by one parent, but her parents live together and do not file a joint tax return; or

(Rule 1200-13-20-.06, continued)

(III) The applicant is under age nineteen (19), or twenty-one (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 nineteen (19), or twenty-one (21) if a full-time student;

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

(iv) For applicants under age nineteen (19), or twenty-one (21) if a full-time student, the applicant's natural, adoptive and step siblings who are under age nineteen (19), or twenty-one (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 according to 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 (Rules 1240-01-04-.12 and .14-.19, and 45 C.F.R. § 233.20). Unless otherwise specified below, these individuals are subject to the following income requirements:

1. ABLE Accounts. Contributions made by a third party, including a trust, and ABLE account earnings are excluded, except that contributions are not deducted from countable income of the individual making the contribution. Distributions from an ABLE account are not income of the designated beneficiary in any month regardless of whether the distribution is for non-housing QDEs, housing QDEs or non-qualified expenses. A distribution from an ABLE account is the conversion of a resource from one form to another.

2. Adoption Subsidies. Payments to an individual from state adoption assistance programs or Title IV-E funds for special needs children are excluded.

3. Alimony Received. Countable.

4. 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.

5. Assistance Payment from another state. Countable.

(Rule 1200-13-20-.06, continued)

6. Bonuses. Countable.

7. Cancelled Debts. Excluded.

8. Capital Gains. Countable.

9. Cash Inheritance. Countable.

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

11. Census Payments. Excluded.

12. Child Support Payments. Countable, both current payments and arrears.

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

14. Child Tax Credit Payments. Excluded.

15. Combat Pay. Excluded.

16. Commissions. Countable.

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

18. Contractual Payments. Countable.

19. 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.

20. 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.

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

22. Differential Payments. Countable.

23. Domestic Volunteer Service Act Payments. Payments made to volunteers under the Domestic Volunteer Service Act are excluded, unless the Corporation for National and Community Service (CNCS) determines that the value of the payments, based on the number of hours served, are equal to or greater than the federal or state minimum wage where the volunteer is serving, whichever is higher. This includes payments made to foster grandparents, senior companions, and persons serving in the Retired Senior Volunteer Program (RSVP) and Americorps VISTA.

24. Dwelling-Related Assistance. Excluded if housing assistance is provided by HUD or USDA's Rural Housing Service.

25. Earned Income Tax Credits. Excluded.

(Rule 1200-13-20-.06, continued)

26. Earned In-Kind Wages. Countable.

27. Economic-Impact Payments. Excluded.

28. Educational Income. Excluded. Includes: Pell Grants, Federal SEOG, Federal Student Loans, State Student Incentive Grants, Work Study, and any student financial assistance received under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs education assistance programs. Other grants, scholarships, fellowships, or gifts are excluded to the extent they are used or set aside for educational expenses.

29. FF/TANF Payments. Excluded.

30. Farming Income. Countable.

31. Fishing Income. Countable.

32. Gambling Prizes and Awards. Countable.

33. Gifts. Cash gifts are countable unless excluded as infrequent or irregular income.

34. Income Not Pursued. Excluded.

35. Income Produced from Resources. Income generated by an excluded resource is countable unearned income. Income generated by a countable resource is excluded as income.

36. Inheritance Cash. Countable.

37. Interest Income. Interest earned on a countable resource is excluded as unearned income. Interest earned on an excluded resource is countable as income, unless specifically excluded under a Federal statute.

38. Interest on Burial Funds and Spaces. Excluded.

39. Irregular or Infrequent Income. Up to $30.00 of unearned or earned income received infrequently or irregularly per quarter is excluded.

40. Jury Duty Pay. Countable unless the income is turned over to an applicant’s employer.

41. Long Term Care (LTC) Insurance Payout. Payments from long term care insurance used for medical care are excluded.

42. Low Income Home Energy Assistance Payments (LIHEAP). Excluded.

43. Military Allowances. Cash allowances paid to active-duty service members and their families for housing, food, clothing and special circumstances count as earned income in the month of receipt. The basic allowance for subsistence (BAS), paid to military personnel to offset the cost of meals, counts as earned income. The basic allowance for housing (BAH) counts as earned income when the payment is made to military personnel living in private housing. When the BAH is paid to service members living on base or in privatized military housing and the allowance is paid and deducted from the service member’s pay in the same month or paid directly to the housing contractor, the BAH is excluded.

(Rule 1200-13-20-.06, continued)

44. Older Americans Act Benefits. Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, are excluded.

45. PASS Income. Any earned or unearned income received and used to fulfill an approved plan to achieve self-support is excluded.

46. 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.

47. Pensions. Countable.

48. 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 her own use is countable income to the protective payee. Even if the protective payee retains a fee for her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.

49. Railroad Retirement Payments. Countable.

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

51. 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 excluded.

52. Royalties and Honoraria. Countable.

53. Self-Employment Income. Net earnings are countable.

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

    (i) Agent Orange Settlement Payments;

    (ii) Alaska Native Claims Settlement Act exclusions;

    (iii) Criminal Victims Compensation Funds paid to crime victims;

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

(Rule 1200-13-20-.06, continued)

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

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

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

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

(V) Tribes or groups under P.L. 93-134; and

(VI) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 95-433).

(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) German Reparation Payments;

(vii) Japanese-American and Aleutian Restitution Payments;

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

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

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

55. Severance. Countable.

56. Sheltered Workshop. Countable.

57. Sick/Disability Payments. Countable.

58. Social Security Payments. Countable.

59. Social Service Payments. Excluded.

60. SSI Payments. Excluded.

61. 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.

62. 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.

63. Tips. Countable.

(Rule 1200-13-20-.06, continued)

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

65. Unemployment Compensation. Countable.

66. U.S. Department of Veterans Affairs Payments. Educational benefits, VA Aid & Attendance, and VA payments from Unusual Medical Expenses are excluded. VA Disability and VA Pension payments made to a veteran are countable. Augmented VA, Apportioned VA, and VA Survivor (DIC) payments are countable for the dependent spouse, child or parent for whom or to whom the benefits are paid.

67. Wages. Countable.

68. Work Study Payments. Excluded.

69. Workers' Compensation. Countable as unearned income to the extent it is not earmarked and used for the purpose for which it is paid (i.e., medical bills or legal expenses).

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

1. ABLE Accounts. ABLE account balances and distributions from an ABLE account for a QDE are not a countable resource of the designated beneficiary. Distributions from an ABLE account are countable as a resource when:

   (i) Distributions are retained past the month of receipt for non-qualified disability expenses;

   (ii) Qualified disability expenses (QDE) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses, and basic living expenses.

2. Annuities. An annuity is a countable resource when it is revocable, assignable, or if it can be sold.

   (i) If an annuity is an excluded resource, payments being received from the annuity are countable unearned income. If the annuity is a countable resource, any payments being received from the annuity are excluded.

   (ii) The countable resource value of an annuity is its Fair Market Value (FMV). If the applicant is able to provide the FMV of the annuity, verified by two (2) credible sources in the legitimate business of selling and purchasing annuities, accept the verified value.

   (iii) If the applicant does not provide two (2) credible statements of FMV, multiply the total annual payment by the period remaining to determine the countable value. If the period of the annuity is based on an annuitant's

(Rule 1200-13-20-.06, continued)

lifetime, the annual payments are multiplied by the annuitant's life expectancy, according to SSA's Period Life Table. If the annuity is a "period certain" annuity, annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. The calculated value of an annuity may be rebutted by providing two (2) credible statements of FMV amounts.

3. 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.

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

5. Burial Plot. Exclude one burial plot per household member.

6. Prepaid Burial Agreements or Burial Trusts. Exclude one burial agreement or burial trust with equity value of $1,500.00 or less per family member.

7. Cash. Countable.

8. 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.

9. 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.

10. Child Tax Credit Payments. Excluded for twelve (12) months following receipt.

11. 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:

(Rule 1200-13-20-.06, continued)

(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 contract is the unpaid loan principal. Any portion of a payment that represents the loan principal is a conversion of a resource. Any portion of a payment that represents interest is considered unearned income in the month of receipt and a resource thereafter. The value of the contract may be excluded from 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.

12. Educational Income. All educational income is excluded as a resource, including student financial assistance received under Title IV of the Higher Education Act and the Bureau of Indian Affairs. 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 educational expenses are excluded as a resource.

13. 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.

14. 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.

15. Household Goods and Personal Effects. Excluded.

16. Individual Development Account (IDA). Up to $5,000.00 in the account is disregarded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions to the account.

17. Income-Producing Resource. Countable if accessible to the individual.

18. Sick and Disability Insurance. Excluded.

19. Burial Insurance. Excluded.

20. Items of Unusual Value. Exclude up to $2,000.00 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 $2,000.00, the amount that exceeds $2,000.00 is countable towards the resource limit.

21. 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:

(Rule 1200-13-20-.06, continued)

(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 or Self-Employment in this Subparagraph.

(III) The terms of the life estate contract prevent the holder from selling 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.

22. Life Insurance. Excluded.

23. 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.

24. 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 is not actively engaged in the production of income, the equity value of the rights is countable.

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

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

27. 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.

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.

(Rule 1200-13-20-.06, continued)

29. 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 her share in the note or loan. The equity value of the note/loan is countable.

30. Prorated as Income. Excluded.

31. 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 in this Subparagraph); or

    (v) Real property excluded under a conditional assistance agreement between the individual and the State. The individual must make reasonable efforts to sell the property at its current market value and repay the State for medical expenses covered by TennCare during the exclusion period with the proceeds of the sale. Exemption of the real property is not to exceed nine (9) months. Only one (1) parcel of property may be excluded under a conditional assistance agreement per period of eligibility.

        (I) Repayment of medical expenses covered by TennCare 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 nine (9) months, the property is considered inaccessible so long as reasonable efforts to sell the property continue.

32. 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 twenty (20) hours per week.

33. Retirement Accounts and Pension Plans. Excluded up to $20,000.00. Money held in an IRA, 401(K), or Keogh in excess of $20,000.00 is countable, minus any penalty for early withdrawal. Pension funds that are not accessible are excluded as a resource. If the pension becomes accessible due to retirement or termination it becomes a countable resource.

34. 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;

(Rule 1200-13-20-.06, continued)

(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; or

(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 (and interest from 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 Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

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

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 95-433); 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);

(Rule 1200-13-20-.06, continued)

(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;

(xi) Criminal Victims Compensation Funds paid to crime victims (excluded for nine (9) months); or

(xii) Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

36. SSI/SSA Retroactive Payments. Excluded for nine (9) months after the payment is received and countable after the nine (9) month exclusion period.

37. Stocks, Bonds and Mutual Funds. Countable if asset is held for personal use. Stocks, bonds or mutual funds may be excluded if held for the purposes listed below:

(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 when essential for the production of earned income.

39. Trusts. Countable or excluded, when the applicant or household member is either the trust's trustee or beneficiary, 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 as specified in 42 U.S.C. § 1396p(d).

40. Uniform Gifts to Minors Act (UGMA) Assets or Property. Excluded for individuals who have not reached the age of majority (as established by the state law controlling such gift). Counted for individuals who have reached the age of majority (as established by the state law controlling such gift).

41. Uniform Transfers to Minors Act (UTMA) Assets or Property. Excluded for individuals who have not reached the age of majority (as established by the state law controlling such transfer). Counted for individuals who have reached the age of majority (as established by the state law controlling such transfer).

(Rule 1200-13-20-.06, continued)

42. Vehicles. Exclude up to $4,600.00 of the equity value of one (1) 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 $50.00 per month per household if a child living in the home receives child support payments (current only).

2. Earned Income Disregard. Disregard $90.00 per month from each household member's total earned income.

3. Payments made on Behalf of Dependents within the Home. Disregard up to $175.00 per month of day care expenses per dependent age two (2) or older. Disregard up to $200.00 per month of day care expenses per dependent under age two (2).

4. Student Income. Disregard the earnings of dependent children who are included in the household composition and are full-time or part-time students and are not working full time. Disregard the earnings of a part-time student who works part-time. Earnings of a part-time student who works full time are not to be disregarded.

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

1. For unmarried applicants, the following individuals are included in the applicant's household for Child Medically Needy, if living in the home:

(i) The applicant;

(ii) The applicant's children under age twenty-one (21);

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

(iv) The applicant's natural or adoptive parents; and

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

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

3. For married applicants, the following individuals must be included in the applicant's household for Child Medically Needy, if living in the home.

(i) The applicant;

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

(iii) The applicant's unborn child(ren); and

(Rule 1200-13-20-.06, continued)

(iv) The applicant's spouse (if under age 21 and applying for Medical Assistance).

(v) When the applicant's spouse is living in the home and is over age 21 or under age 21 and not applying for Medical Assistance, the spouse's income and resources are deemed to the applicant. When income and resources are deemed from a spouse, the household size will be increased to account for the deemed spouse.

4. The Child Medically Needy applicant's step parent living in the home is not included in the child's household.

5. The following individuals must be included in the Medically Needy Qualified Pregnant Woman applicant's household, if living in the home:

(i) The Pregnant Woman applicant;

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

(iii) The applicant's spouse, if under 21 and applying for Medical Assistance; and

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

(v) If the applicant's spouse is living in the home and is over age 21 or under age 21 and not applying for Medical Assistance, the spouse's income and resources are deemed to the applicant. When income and resources are deemed from a spouse, the household size will be increased to account for the deemed spouse.

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

(f) Spenddown.

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, spenddown will not be necessary. Applicants may reduce available monthly income with countable expenses, 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 spenddown:

(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 (3) calendar months prior to the month of application, whether paid or unpaid.

(Rule 1200-13-20-.06, continued)

(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 (3) 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 twelve (12) months, he will be expected to meet spenddown again as described in this section, except verified expenses that are documented in the enrollee's Medicaid record can be carried forward 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 spenddown can be carried forward to the next eligibility determination. If an enrollee loses eligibility at any point, the carry forward of unpaid medical expenses ends and the enrollee must meet spenddown 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 spenddown 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 spenddown 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 applicant's 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 the applicant's FRR is legally obligated to pay their 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 spenddown expense only when payment is due, even if paid in another month;

(Rule 1200-13-20-.06, continued)

(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 spenddown 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., spenddown 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 an individual's home, if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder and ordered by a provider acting within the provider's scope of practice. 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 devices. Artificial teeth, limbs, hearing aids and component parts, eyeglasses and crutches.

(Rule 1200-13-20-.06, continued)

(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, including but not limited to bus, taxi, train, or plane fares, using the Internal Revenue Service's standard mileage rate for business use for each mile that the individual's car is used for medical purposes, in addition to parking fees and tolls.

(xvii) Over the counter (non-prescription) medicine. $10.00 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 $10.00 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 spenddown 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. Individuals applying for SSI-Related categories.

2. MSP Applicants.

3. Individuals applying for Institutional Eligibility.

4. Individuals applying for ECF CHOICES.

(Rule 1200-13-20-.06, continued)

(b) Income Determinations. Income countable for purposes of individuals described in this paragraph is defined at 20 C.F.R. §§ 416.1100, et seq., and as set forth below, except gross income, under the Institutional Eligibility category, in accordance with 42 C.F.R. § 435.1005, does not take into account the income exclusions under 20 C.F.R. § 416.1112 and 20 C.F.R. § 416.1124, unless specified under another Federal statute. Unless otherwise specified in this rule, these individuals are subject to the following income requirements:

1. ABLE Accounts. Contributions made by a third party, including a trust, and ABLE account earnings are excluded, except that contributions are not deducted from countable income of the individual making the contribution. Distributions from an ABLE account are not income of the designated beneficiary in any month regardless of whether the distribution is for non-housing QDEs, housing QDEs or non-qualified expenses. Distribution from an ABLE account is the conversion of a resource from one form to another.

2. 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.

3. Alimony. Countable.

4. Americorps and Americorps NCCC. Cash or in-kind payments are excluded.

5. 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. Payments are also excluded if an annuity is paid by a state to an individual or spouse based on the state's determination that the individual is a veteran who is aged, blind or disabled.

6. Bonuses. Countable.

7. Care and Contribution in Exchange for a Transferred Asset. Countable.

8. Canceled Debts. Excluded.

9. Capital Gains. Countable.

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

11. Census Income. Excluded.

12. Child Support Arrearage. Countable to the child(ren) the payments are intended to support. Exclude one-third (1/3) of the child support arrearage payment paid by an absent parent to or for an eligible child under age 18 or under age twenty-two (22) if a student regularly attending school. The one-third (1/3) exclusion does not apply to ineligible children.

13. Child Support Payments. Countable to the child(ren) the payments are intended to support. Exclude one-third (1/3) of the child support payment paid by an absent parent to or for an eligible child under age 18 or under age twenty-two (22) if a student regularly attending school. The one-third (1/3) exclusion does not apply to ineligible children.

14. Child Tax Credit Payments. Excluded.

(Rule 1200-13-20-.06, continued)

15. Commissions. Countable.

16. Combat Pay. Excluded.

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

18. Contractual Payments. Countable.

19. 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.

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

21. Differential Payments. Countable.

22. Domestic Volunteer Service Act Payments. Payments made to volunteers under the Domestic Volunteer Service Act are excluded, unless the Corporation for National and Community Service (CNCS) determines that the value of the payments, based on the number of hours served, are equal to or greater than the federal or state minimum wage where the volunteer is serving, whichever is higher. This includes payments made to foster grandparents, senior companions, and persons serving in the Retired Senior Volunteer Program (RSVP) and Americorps VISTA.

23. Earned Income Tax Credits. Excluded.

24. Earned In-Kind Not Food or Shelter. Excluded.

25. Earned In-Kind Wages. Countable.

26. Economic-Impact Payments. Excluded.

27. Educational Income. Excluded. Includes: Pell Grants, Federal SEOG, Federal Student Loans, State Student Incentive Grants, Work Study, and any student financial assistance received under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs education assistance programs. Other grants, scholarships, fellowships, or gifts are excluded to the extent they are used or set aside for educational expenses.

28. Farming/Fishing Income. Countable.

29. Gambling Prizes and Awards. Countable.

30. Gifts. Countable.

31. Income Not Pursued. Countable.

32. 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.

33. Inheritance Cash. Countable.

(Rule 1200-13-20-.06, continued)

34. Interest Income. Interest earned on a countable resource is excluded as unearned income. Interest earned on an excluded resource is countable as income, unless specifically excluded under a Federal statute.

35. Interest on Excluded Burial Arrangements, Funds, and Spaces. Excluded.

36. Irregular or Infrequent Income. Exclude up to $60.00 per calendar quarter of unearned income when it is received infrequently or irregularly. Exclude up to $30.00 per calendar quarter of earned income when it is received infrequently or irregularly.

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

38. Long Term Care Insurance Payments. Countable if the payment is not assigned or provided to the nursing home, HCBS provider, or MCO.

39. Military Allowances. Countable. The basic allowance for housing (BAH) is counted as earned income when the payment is made to military personnel living in private housing. The BAH should be treated as unearned income in the form of in-kind support and maintenance (ISM) subject to the Presumed Maximum Value (PMV) rule for service members and their families who live on base or in privatized military housing.

40. Older Americans Act Payments. Count only wages or salaries.

41. PASS Payments. Any earned or unearned income received and used to fulfill an approved plan to achieve self-support is excluded.

42. 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.

43. Pensions. Countable.

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 her own use is countable income to the protective payee. Even if the protective payee retains a fee for her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.

45. 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.

46. Royalties and Honoraria. Countable.

47. Self-Employment. Net earnings are countable.

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

    (i) Agent Orange Settlement Payments (and interest from 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 Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

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

        (V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 95-433); 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) Criminal Victims Compensation Funds paid to crime victims.

49. Severance. Countable.

50. Sheltered Workshop Payments. Countable.

(Rule 1200-13-20-.06, continued)

51. Sick/Disability Payments. Countable.

52. Social Security Payments. Countable.

53. Social Service Payments. Excluded.

54. SSI. Excluded.

55. 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.

56. Tips. Tips that total more than $20.00 in a calendar month from any one employer are countable earned income. Tips totaling less than $20.00 in a calendar month are countable unearned income.

57. 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.

58. 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 depending on the source. If countable, it is subject to either the Value of the One-Third Reduction (VTR) rule or the Presumed Maximum Value (PMV) rule.

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

60. Unemployment Compensation. Countable.

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

    (i) Aid and Attendance and Housebound Allowances. Excluded.

    (ii) Apportioned. Payments made to a dependent spouse, child, or parent are countable for the individual to whom the benefits are paid.

(Rule 1200-13-20-.06, continued)

(iii) Augmented Benefit. Payments received on behalf of a dependent spouse, child, or parent are countable for the individual for whom the benefits are paid.

(iv) Compensation. Countable.

(v) 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.

(vi) Dependency and Indemnity Compensation (DIC). Countable.

(vii) Educational Benefits. Excluded.

(viii) Payments for Unreimbursed Medical Expenses. Excluded.

(ix) Pension. Countable. If an institutionalized veteran receives a VA improved pension limited to $90.00 per month, the VA pension is excluded.

62. Wages. Countable.

63. Workers' Compensation. Countable as unearned income to the extent it is not an expense attributable to obtaining the compensation.

64. WIOA Payments. Countable, unless the payments are for supportive services, such as child care, transportation, or job placement services. Wages earned by a student in the Job Corps program may be excluded under the student earned income exclusion.

65. Work Study Payments. Excluded.

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

1. ABLE Accounts. Distributions from an ABLE account are excluded if used or intended to be used for QDEs as long as the distributions are identifiable. Distributions from an ABLE account used for non-qualified expenses are excluded if spent in the month of receipt. Distributions from an ABLE account are countable as a resource when:

(i) Distributions are retained past the month of receipt and are used for or intended to be used for non-qualified disability expenses; or

(ii) Distributions are retained past the month of receipt and were previously excluded because intended for a QDE, but used for a non-qualified expense. Count the amount of funds used as a resource the first of the month in which funds were spent; or

(iii) Distributions are retained past the month of receipt, have not been spent, and the intent to use the funds for a QDE has changed. Count the retained funds as a resource the first of the following month.

(iv) Qualified disability expenses (QDE) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the

designated beneficiary. In general, a QDE includes, but is not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses, and basic living expenses.

2. Annuities are countable resources for individuals when accessible according to 20 C.F.R. § 416.1201. An annuity is a countable resource when it is revocable, assignable, or can be sold.

   (i) If the annuity is an excluded resource, payments being received from the annuity will be countable unearned income, except as excluded at Subpart (v). If the annuity is a countable resource, any payments being received from the annuity are excluded.

   (ii) Generally, annuities are revocable while in the accumulation phase though an owner will not receive a full refund, unless the annuity is cancelled during the free-look period. Once an annuity has been annuitized, the annuity is excluded as a resource if the funds are unavailable in a lump sum.

   (iii) The countable value of an annuity during the free-look period is the purchase value. The countable value of an annuity during the accumulation phase is the cash value minus any withdrawals and surrender charges or penalty fees for early withdrawal. If an annuity contains a provision that allows an individual to cash in a contract after annuitization, the countable value of the annuity is the commuted cash value, i.e., the present value of all future payments.

   (iv) Distributions from an annuity, such as systematic withdrawals and required minimum distributions (RMDs), are considered conversions of a resource rather than income.

   (v) Any amount of an annuity held following the month of receipt is a countable resource, except when an annuity is a state annuity for certain veterans. A state annuity is an annuity paid by a state to an individual or an individual's spouse based on the state's determination that the individual is a veteran who is aged, blind or disabled.

   (vi) Annuities that are funded by a pension or a retirement fund held by an employer or union should not be counted as a resource, while the individual is employed, if termination of employment would be necessary to access the funds.

   (vii) Individuals applying for or receiving LTSS must meet additional requirements regarding asset transfers and exclusion of annuities at Rule .06(3)(h).

3. 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.

4. 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 $6,000.00 per individual. Transport costs which cause the trust value to exceed $6,000.00 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.

(Rule 1200-13-20-.06, continued)

(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 $1,500.00 in resources to cover expenses connected to 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 $1,500.00 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 $1,500.00 or less; and

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

5. 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.

6. Cash. Countable.

7. 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.

8. 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.

9. 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.

10. Child Tax Credit Payments. Excluded for twelve (12) months following receipt.

11. Christmas Club Accounts. Countable minus any withdrawals and surrender charges or penalty fees for early withdrawal.

12. 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

(Rule 1200-13-20-.06, continued)

principal. The value of the contract is the unpaid loan principal. Any portion of a payment that represents the loan principal is a conversion of a resource. Any portion of the payment that represents interest is considered unearned income in the month of receipt and a resource thereafter. 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.

13. Economic-Impact Payments. Excluded.

14. Educational Income.

(i) Educational income received under Title IV of the Higher Education Act or under the Bureau of Indian Affairs is excluded as a resource.

(ii) Any portion of a VA educational benefit that is a withdrawal of a veteran's own contribution is a countable resource if retained in the month following the month of receipt.

(iii) Other grants, scholarships, fellowships and gifts intended to pay for tuition, fees or educational expenses are excluded for nine (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.

15. 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 $6,000.00 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.

16. 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.

17. 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 individual 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 Subparts (i) and (ii) above are true and the individual's equity interest does not exceed the home equity limit established by CMS, 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 twenty-one (21), or a blind or permanently and totally disabled child is residing in the home. An

institutionalized individual whose home exceeds the home equity limit established by CMS and who does not have a spouse, a child under age twenty-one (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 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 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 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.

18. 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.

19. Income-Producing Resource.

(i) For Institutional Eligibility financial determinations of individuals who are in an institution or seeking services under a 1915(c) HCBS waiver program and for MSP financial determinations, the equity value in business/non-business resources (land, buildings, equipment, supplies, inventory, tools of a tradesperson, livestock of a farmer, cash on hands, accounts receivable, etc. which are used in the person's trade or business, or in the employment of a family member or by the individual as an employee) used to produce income are excluded.

(ii) For all remaining ABD financial determinations, exclude up to $6,000.00 of an individual's equity in an income-producing resource if it produces a net annual income to the individual of at least six percent (6%) of the property's equity value. If the individual's equity value is greater than

$6,000.00, the amount that exceeds $6,000.00 is countable towards the resource limit.

(I) If an income-producing resource does not produce a net annual income of at least six 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 six percent (6%) test is met. Then the amounts of the individual's equity in all of those properties producing six percent (6%) are totaled to determine if the total equity of all properties is $6,000.00 or less. If the total equity value in the properties that meet the six percent (6%) rule is over the $6,000.00 equity limit, the amount exceeding $6,000.00 is counted as a resource.

20. Insurance. Exclude Sick and Disability Insurance and Burial Insurance.

21. 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 $500.00. 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.

22. 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 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 lives 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.

23. 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 $1,500.00 per owner.

24. 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.

25. 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 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.

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

27. Personal Resource. Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and his family.

28. Personal Consumption. Exclude up to $6,000.00 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 $6,000.00 is a countable resource.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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 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 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;

(Rule 1200-13-20-.06, continued)

(II) Business or Self-Employment; and

(III) Proceeds from the Sale of a Home.

34. 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.

35. Prorated as Income. Excluded.

36. Qualified Tuition Savings Plan (529 Plans). Countable minus any early withdrawal penalties.

37. 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.

38. Retirement Funds. Retirement funds owned by an individual and held in an IRA, 401(k), or other work-related plan are resources if an individual has the option of withdrawing funds in a lump sum. The value of a retirement fund is the amount of money that the individual can currently withdraw less any penalty for early withdrawal. Retirement funds are not counted as resources if termination of employment is necessary to access the funds or an individual is eligible for and receiving periodic benefits (e.g., pension or annuity). Distributions and systematic withdrawals from a retirement account are conversions of a resource rather than income when an individual can withdraw any of the remaining account balance in a lump sum. Retirement funds are excluded from deeming if owned by an ineligible spouse or an ineligible parent (for non-institutional categories only).

(i) Funds held in a 401(k) or 403(b) retirement account are countable when an individual is no longer job-attached. Funds in a 401(k), part of a profit-sharing plan or stock bonus plan, or in a 403(b) retirement account are also countable when an individual reaches age 59 ½.

(ii) Funds held in an IRA are considered accessible any time. Count the equity value of an accessible IRA when determining eligibility. An IRA held in the form of an annuity will be evaluated as an annuity.

(iii) A Keogh plan established for a self-employed individual is considered accessible and is counted as a resource to the individual even if the household is not actually accessing the funds.

(iv) If the accessibility of a retirement fund cannot be determined based on the documentation received, the summary plan description or a written statement from the plan administrator shall be requested.

(v) Retirement funds are considered nonliquid resources unless there is evidence to suggest otherwise. An individual with excess retirement funds who is otherwise Medicaid-eligible may qualify for conditional assistance while waiting for retirement funds to become available, if the individual agrees in writing to use the funds to repay the medical assistance he received during the conditional assistance period.

39. 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).

40. 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 or groups under P.L. 93-134;

(Rule 1200-13-20-.06, continued)

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 95-433); 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 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 nine (9) months);

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

(xi) Criminal Victims Compensation Funds paid to crime victims (excluded for nine (9) months); and

(xii) Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

41. Social Security Accounts. Countable. Social Security Accounts are checking accounts specifically designed and held for Social Security Benefits.

42. SSI/SSA Retroactive Payment. Excluded for nine (9) months after the payment is received and counted after that nine (9) month exclusion period.

43. 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.

44. Tools of the Trade. Excluded.

45. 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 as specified in 42 U.S.C. § 1396p(d).

46. Uniform Gifts to Minors Act (UGMA) Assets or Property. Excluded for individuals who have not reached the age of majority (as established by the state law controlling such gift). Counted for individuals who have reached the age of majority (as established by the state law controlling such gift).

47. Uniform Transfers to Minors Act (UTMA) Assets or Property. Excluded for individuals who have not reached the age of majority (as established by the state law controlling such transfer). Counted for individuals who have reached the age of majority (as established by the state law controlling such transfer).

48. 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 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. Nonliquid resources, which are not exempt under another resource provision, are exempt as a resource if the individual enters into a conditional assistance agreement with the State. Nonliquid resources include real and personal property that cannot be converted to cash within twenty (20) days. The individual must dispose of the excess nonliquid resources at current market value within the time periods specified below and use the proceeds to repay the State for medical expenses covered by TennCare during the period of conditional assistance.

1. The exclusion period for real property is not to exceed nine (9) months. The exclusion period for personal property is not to exceed three (3) months, however a three (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 to make reasonable efforts to sell the property.

2. Repayment of medical expenses covered by TennCare 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 (b) above, individuals described in Subparagraph (a) are subject to the following expense requirements.

1. Child Support Disregard. One-third (1/3) of child support payments (including child support arrearages) paid by an absent parent to or for a child under age 18, or under age twenty-two (22) and a student regularly attending school, is excluded per month.

(Rule 1200-13-20-.06, continued)

2. General Deduction. A $20.00 monthly General Deduction is allowed per household, and is applied to unearned income. If any of the $20.00 deduction 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.

3. Student Earned Income Exclusion (SEIE). Applies to the earnings of an individual who is under age twenty-two (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.

4. Earned Income Deduction. The first $65.00 of the earned income of each aged, blind or disabled individual is disregarded.

5. Impairment-Related and Blind 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 Impairment-Related Work Expenses (IRWE) are not the same. BWE and IRWE apply only to earned income. In order to deduct either BWE or IRWE, the individual must be:

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

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

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

6. One-Half Disregard. One-half of the remaining earned income in the month is disregarded. This disregard is deducted after Impairment-Related Work Expense (IRWE), but before deducting Blind Work Expenses (BWE).

(f) Mandatory deductions such as FICA and withholding tax on pensions and other unearned income are not included in gross income for Institutional Medicaid and the Medicare Savings Programs.

(g) 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" available, and the amount of income "deemed" or available to an individual. See 20 C.F.R. §§ 416.1160, et seq., and 42 C.F.R. § 435.602.

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

(i) The applicant; and

(ii) The applicant's eligible spouse, if applicable.

(Rule 1200-13-20-.06, continued)

2. For Medicare Savings Programs (MSPs), include the applicant's spouse if living in the home, the applicant's natural born or adoptive children under age twenty-one (21) in the household, and the applicant's step-children under age twenty-one (21) if the requirements of (g)3. below are met. If a spouse is living in the home of an MSP applicant who is receiving HCBS, the spouse is not included in the household composition, and the spouse's income and resources are not considered.

3. Step-children are considered in household composition when they live in the home and their natural parent is the spouse of the applicant and is included in the applicant's household.

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

5. Parent-to-child deeming applies when a blind or disabled child under age eighteen (18) 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. The needs of step-parents and step-siblings are also considered when they live in the home with the applicant and natural or adopted parent, and the step-parent is married to the natural or adopted parent. Children for whom a child allocation is received must be unmarried and under age eighteen (18), or under age twenty-two (22) and a student. 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:

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

   (ii) SSI-Related Groups; and

   (iii) ECF CHOICES except those age 17 or older who meet institutional level of care, those enrolled prior to November 23, 2020, those who will be enrolled in ECF CHOICES Group 7 (Intensive Behavioral Family Supports), and those transitioning from ECF CHOICES Group 7 to ECF CHOICES Group 4 (Essential Family Supports) as defined in TennCare 1115 Demonstration Waiver III.

6. 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 applies when the spouses share a living arrangement, i.e., live in the community or home together. The applicant/enrollee's ineligible spouse is included in the household if the income of the spouse is deemed to the applicant/enrollee. Spousal deeming applies to the following:

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

   (ii) SSI-Related Groups.

7. Financial eligibility for Institutional Eligibility categories and the ECF CHOICES Demonstration Groups is determined based on a household size of one. The

(Rule 1200-13-20-.06, continued)

only included household member is the applicant/enrollee. However, the Community Spouse and dependents do impact budgeting of the post-eligibility treatment of income (i.e. patient liability), and the community spouse's resources are considered in the resource assessment.

(h) Qualifying Income Trusts (QIT) for Institutional and ECF CHOICES Applicants.

1. Individuals who are receiving or will receive nursing facility or ICF/IID services or Home and Community Based Services (HCBS) offered either through the CHOICES or ECF CHOICES program or through a Section 1915(c) HCBS waiver program and whose income exceeds the income limitations in Rule .08 may establish a QIT. 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, SSI, and other monthly income created for the purpose of establishing income eligibility for TennCare coverage when an individual is or soon will be confined to a nursing facility or ICF/IID or will receive HCBS offered either through the CHOICES or ECF CHOICES program or through a Section 1915(c) HCBS waiver program.

3. An individual is eligible to establish a QIT if his income is above the level at which he would be financially eligible for nursing facility or ICF/IID services, HCBS offered either through the CHOICES or ECF CHOICES program, or through a Section 1915(c) HCBS waiver program.

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 income limitations in Rule .08. 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 income limitations in Rule .08, the individual is not financially eligible for the Institutional Eligibility category or ECF CHOICES.

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 $20.00, or other verified amount, for a QIT maintenance fee.

(iii) The sole beneficiary of the Trust is 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 TennCare within three (3) months after the death of the individual or termination of the Trust, whichever is sooner, along with an accounting of the payments from the Trust. TennCare may grant an extension if a written request is submitted within two (2) months of the termination of the Trust.

(vi) Allowable payments from the Trust include:

(I) Personal Needs Allowance (PNA). The amount the individual is allowed to retain for his personal needs under TennCare Medicaid policies.

I. Effective January 1, 2025, this amount is $70 for persons residing in a nursing facility or ICF/IID.

II. For persons receiving HCBS through CHOICES, ECF CHOICES, PACE, the Self-Determination Waiver, the Comprehensive Aggregate Cap (CAC) Waiver, and the Statewide Waiver, this amount is three hundred percent (300%) of the SSI/FBR.

(II) A deduction not to exceed $20.00, or other verified amount, 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) Incurred Medical Expenses. Payment for types of medical or remedial care recognized under State law, but not covered as medical assistance under TennCare Medicaid.

(vii) 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.

(viii) 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.

(i) Annuities.

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

(Rule 1200-13-20-.06, continued)

2. Annuities and Transfer of Assets. An annuity will not be treated as a transfer of assets if the annuity meets the requirements of 42 U.S.C. § 1396p(c)(1)(G).

3. Requirement to name the State as the Remainder Beneficiary. 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).

   (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. If the individual has a community spouse, or a minor or disabled child, the State may be named in the second position following one of these individuals. If the State is named in the second position following a community spouse or child, the annuity must also provide that the State becomes the remainder beneficiary in the first position if the community spouse, child, or their representative disposes of any of the remainder of the annuity for less than fair market value.

   (ii) 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.

   (iii) 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.

4. Annuity Transactions. Certain annuity transactions may be treated as a transfer of assets for less than fair market value (FMV) according to 42 U.S.C. § 1396p(e).

   (i) Annuity transactions made by an individual, or by someone acting on an individual's behalf, are considered improper transfers if any of the individual's assets are disposed of for less than FMV.

   (ii) Transactions include any action that changes the course of payments to be made by an annuity or the treatment of the income or principal of an annuity. These actions include additions of principal, elective withdrawals, requests to change the distribution of an annuity, elections to annuitize the contract and other similar actions.

   (iii) Routine changes (e.g., notification of an address change or death or divorce of a remainder beneficiary) and changes beyond an individual's control are not considered transfers of assets for less than FMV.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-117, 71-5-134, and 71-5-147.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Repeal and new rule filed May 24, 2019; effective August 22, 2019. Amendments filed May 13, 2022; effective August 11, 2022. Amendments filed August 25, 2025; effective November 23, 2025.*

**1200-13-20-.07 FAMILY AND CHILD ELIGIBILITY GROUPS.**

(1) Caretaker Relatives.

(Rule 1200-13-20-.07, continued)

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Individual must be a parent or caretaker relative of a dependent younger than age eighteen (18), or 18 and a full-time student, and must agree to cooperate with 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 .06.

(e) Income Limitation: Household income cannot exceed one hundred percent (100%) of the FPL.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later. Retroactive Eligibility may be granted to eligible Pregnant Women.

(h) Other:

1. Individuals in this category may also be eligible for Extended Medicaid as described in 42 C.F.R. § 435.115 and Transitional Medicaid as described in 42 C.F.R. § 435.112.

2. An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(2) TennCare Pregnant Women.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Individual must be a Pregnant Woman. 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 .06.

(e) Income Limitation: Household income cannot exceed two hundred fifty percent (250%) of the FPL. See Rule .06.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later. Retroactive Eligibility may be granted to eligible applicants.

(h) Other:

1. An individual in this category may receive Continuous Eligibility. See Rule .09.

(Rule 1200-13-20-.07, continued)

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 Eligibility or ECF CHOICES category.

(3) Presumptive Eligibility for Pregnant Women.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .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 a Pregnant Woman 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 .06.

(e) Income Limitation: Household income cannot exceed two hundred fifty percent (250%) of the FPL. See Rule .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 either the last day of the month following the month a presumptive eligibility determination was made, 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, 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 .02.

(b) Technical Requirements: See Rule .04.

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

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations:

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

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

3. Children from age six (6) to age nineteen (19): Household income cannot exceed one hundred thirty-three percent (133%) of the FPL. See Rule .06.

(f) Resource Limitations: None.

(Rule 1200-13-20-.07, continued)

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later. Retroactive Eligibility may be granted to eligible applicants.

(h) Other:

1. Individuals in this category may also be eligible for Extended Medicaid as described in 42 C.F.R. § 435.115 and Transitional Medicaid as described in 42 C.F.R. § 435.112.

2. Infants born while enrolled in CoverKids will be enrolled in this category if household income is at or below one hundred ninety-five percent (195%) of the FPL.

3. An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman or if the individual is receiving inpatient services and turns age nineteen (19) while hospitalized. See Rule .09.

(5) Deemed Newborns.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04, except Deemed Newborns are not subject to citizenship rules. Newborns without an SSN must be enumerated by age one (1) 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 twelve (12) months or younger. A baby born to a mother eligible for and receiving TennCare Medicaid shall be eligible for TennCare Medicaid for one (1) 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) Former Foster Care Children up to Age 26.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: The individual must be under age twenty-six (26), must have been in foster care under the responsibility of a state until aging out at age eighteen (18) or older, and must have been enrolled in Medicaid at the time he aged out of custody. If an individual aged out of foster care in a state other than Tennessee, the individual must have turned age eighteen (18) on or after January 1, 2023, in order to qualify for this category. Self-attestation of status as Former Foster Care Children Under Age 26, as defined in Rule .02, is accepted unless the state has information that is not reasonably compatible with such attestation.

(d) Income Limitations: None.

(Rule 1200-13-20-.07, continued)

(e) Resource Limitations: None.

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

(g) Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(7) Standard Child Uninsured.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Must be a Medicaid “Rollover” enrollee as defined in Rule .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 .06.

(e) Income Limitations: Household income must be below two hundred eleven percent (211%) of the FPL.

(f) Resource Limitations: None.

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

(h) Other:

1. Includes uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes below two hundred and eleven percent (211%) of the FPL, and who have not purchased insurance even if they have access to it. This is a “grandfathered” eligibility category. If an individual loses eligibility in this category, he will not be able to re-enroll in it.

2. An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(8) Standard Child Medically Eligible.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Must be an uninsured child under age nineteen (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 according to these rules.

(d) Special Application Procedures:

1. Must be a Medicaid “Rollover” enrollee as defined in Rule .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 two hundred eleven percent (211%) of the FPL or higher, he will be sent a ME packet.

4. TennCare will send the enrollee a ME packet with an explanation regarding how to apply for TennCare Standard as a medically eligible individual. 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 ME application information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A ME 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 .06.

(f) Income Limitations: Household income must be at or above two hundred eleven percent (211%) of the FPL.

(g) Resource Limitations: None.

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

(i) Other: An individual in this category may receive Continuous Eligibility. See Rule .09.

(9) CoverKids CHIP Children under Age 19.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Includes children under age 19 who do not have Health Insurance, as defined in Rule .02.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations: Must be ineligible for Medicaid and no more than two hundred fifty percent (250%) of the FPL. See Rule .06.

(Rule 1200-13-20-.07, continued)

(f) Resource Limitations: None.

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

(h) Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19). See Rule .09.

(10) CoverKids Pregnant Women.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04. A CoverKids 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, as defined in Rule .02, or do not have maternity benefits or have exhausted maternity benefits.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations: Must be ineligible for Medicaid and no more than two hundred fifty percent (250%) of the FPL. See Rule .06.

(f) Resource Limitations: None.

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

(h) Other: Eligibility for CoverKids Pregnant Women is continuous through the sixty (60) day postpartum period as defined at 42 C.F.R. § 435.4. See Rule .09. Eligibility for the newborn child continues twelve (12) months from the mother's effective date of eligibility.

(11) 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.

(c) Other: Excluding IE Foster Care, an individual in these categories may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(12) Transitional Medicaid.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(Rule 1200-13-20-.07, continued)

(c) 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 (3) of the previous six (6) 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 (3) of the six (6) months immediately preceding the month the parent or caretaker relative lost eligibility.

(d) 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 (3) of the six (6) 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.

(e) Household size is based upon the MAGI household composition Rule .06.

(f) Income Limitations: See Rule .06.

(13) Extended Medicaid.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Eligible individuals must have been eligible for and receiving benefits for at least three (3) out of six (6) months immediately preceding the month of ineligibility.

(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 (3) of the previous six (6) 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 (3) of the six (6) months immediately preceding the month the parent or caretaker relative lost eligibility.

(e) 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:

(Rule 1200-13-20-.07, continued)

1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three (3) of the six (6) 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 Extended Medicaid.

(f) Household size is based upon the MAGI household composition Rule .06.

(g) Income Limitations: See Rule .06.

(14) Hospital Presumptive Eligibility.

(a) Definition: See Rule .02.

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

(c) Special Eligibility Requirements: Self-attestation of pregnancy or status as Former Foster Care Children Under 26, as defined in Rule .02, 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 .06.

(e) Income Limitation: Household income must not exceed the income standard for the TennCare Medicaid category for which the individual's presumptive eligibility is being determined.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: The date of determination by the qualified entity. The presumptive eligibility period ends either the last day of the month following the month a presumptive eligibility determination was made, 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, or as otherwise agreed to by the Single State Agency and CMS. Applicants are allowed one period of HPE every two (2) calendar years for non-pregnancy-related categories. For Pregnant Women, one (1) period of presumptive eligibility is allowed per pregnancy.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-117, and 71-5-134 and TennCare III Section 1115(a) Medicaid Demonstration Waiver.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019. Amendments filed May 13, 2022; effective August 11, 2022. Amendments filed August 25, 2025; effective November 23, 2025.*

**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 are eligible for TennCare Medicaid. Once SSI payments in Tennessee stop, the

(Rule 1200-13-20-.08, continued)

individual becomes an inactive SSI enrollee who must be reviewed for eligibility in all other categories.

(b) Effective date of eligibility: Date of eligibility as determined by the SSA.

(c) Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(2) Disabled Adult Child.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Disabled adult children who lose SSI eligibility after July 1, 1987 because of the receipt of or increase in DAC payments under Title II of the Social Security Act will remain eligible for Medicaid if the initial entitlement or increase under Title II, whichever caused the ineligibility for SSI, and any subsequent COLA and non-COLA increases, were disregarded. Individuals must have been age 18 or older when SSI terminated.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000.00 for an individual, $3,000.00 for a couple.

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

(g) Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(3) Pickle Passalong.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: TennCare Medicaid benefits are available to individuals who would be eligible for SSI payments if increases in their OASDI due to COLAs were disregarded. Individuals who meet all other non-financial and financial eligibility requirements remain eligible for TennCare Medicaid if they:

1. Currently receive OASDI authorized under Title II of the Social Security Act;

2. Are not currently receiving SSI;

3. Were entitled to both OASDI and SSI benefits in the same month after April 1977; and

4. Have countable income equal to or less than the current SSI Federal Benefit Rate after all COLAs received since the last month in which the individual was eligible for both OASDI and SSI have been deducted.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000.00 for an individual, $3,000.00 for a couple.

(Rule 1200-13-20-.08, continued)

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

(g) Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(4) Widow/Widower.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .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:

1. Was eligible for SSI based on his own disability;

2. Was entitled to the Social Security Widow/Widower benefit any time after the age of fifty (50);

3. Lost SSI eligibility in the first month that the Social Security Widow/Widower benefit was paid;

4. Would be eligible for SSI if the Widow/Widower entitlement and all subsequent COLAs were disregarded;

5. Is not entitled to Medicare Part A; and

6. Is at least age fifty (50) and under age sixty-five (65).

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000.00 for an individual, $3,000.00 for a couple.

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

(g) Other: An individual in this category may receive Continuous Eligibility if the individual is a Pregnant Woman. See Rule .09.

(5) Institutional Eligibility.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements. To gain eligibility in this category, applicants must:

1. Be confined in a Medical Institution at least thirty (30) consecutive days and be either Aged, Blind, Disabled, a child under age twenty-one (21), or a Pregnant Woman;

2. Meet Nursing Facility Level of Care (NF LOC) according to Chapter 1200-13-01; or

3. Receive CHOICES HCBS and meet the medical Level of Care (LOC) eligibility criteria, according to Chapter 1200-13-01, to receive payments for LTSS through CHOICES.

4. An individual who receives hospice services in a nursing facility for any length of time or dies in a nursing facility or ICF/IID prior to thirty (30) days of continuous confinement meets the 30-day continuous confinement requirement.

(d) Household size is based upon the ABD household composition Rule .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 $2,000.00 for an individual.

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

(h) Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(i) 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 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 disregarded during the TennCare Medicaid eligibility determination process because the enrollee purchased an LTCP policy are protected from estate recovery. When the amount of assets disregarded during the TennCare Medicaid eligibility determination process are less than the total benefits paid by the LTCP policy, additional assets up to the total amount of payments made by the LTCP policy may be protected during the estate recovery process.

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 a nursing home applicant uses his funds to purchase a loan, mortgage or promissory note and the purchase agreement does not meet the criteria of this part, the amount of the asset transfer will be the outstanding balance due on the loan, mortgage or promissory note 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.

(j) Transfer of Assets. A transfer of assets is transferring ownership of a resource for less than fair market value (FMV). An applicant requesting payment for LTSS shall not transfer assets for less than FMV on or after the look-back date. The look-back date is sixty (60) months prior to the first date an individual has both applied for Medicaid and is institutionalized or is determined to have met the requirements for HCBS. If an individual is found to have transferred an asset for less than FMV, he will be ineligible for payments for LTSS.

1. An individual shall not receive a period of ineligibility to the extent that the transfer meets the requirements of 42 U.S.C. § 1396p(c)(2).

2. An individual shall not receive a period of ineligibility to the extent that the assets:

(i) Were transferred to a trust established solely for an individual under age 65 and that meets the requirements of 42 U.S.C. §1396p(d)(4)(A);

(ii) Were transferred to a trust that meets the requirements of 42 U.S.C. §1396p(d)(4)(B); or

(iii) Were transferred to a trust established solely for the benefit of an individual under the age of 65 who is disabled according to the Social Security Administration and that meets the requirements of 42 U.S.C. §1396p(d)(4)(C). Trusts created pursuant to this section shall not include language disallowing repayment to the state in the event the claim exceeds the amount remaining in the trust.

(iv) All trusts may be subject to review annually or upon request for a full accounting by TennCare. Failure to respond to such requests or provide this information may result in the ineligibility of an individual.

3. The transfers indicated below, if occurring on or after February 8, 2006, may be considered a transfer of assets for less than FMV with respect to an individual applying for Medicaid based on institutionalization:

(i) If the transfer of assets occurs on or after the look-back date.

(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 on or after the look-back date.

(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 on or after the look-back date.

(k) 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) The penalty period is 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 date the individual is eligible for Medicaid and would otherwise be receiving LTSS through the CHOICES program but for a penalty or the first day of the month of the transfer, whichever is later. The penalty period for HCBS begins the date the individual meets all eligibility requirements and would otherwise be receiving LTSS through the CHOICES program but for a penalty or the first day of the month of the transfer, whichever is later. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a 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 Eligibility category while payments for LTSS are

withheld. Applicants for, or enrollees in, HCBS cannot be eligible for an Institutional Eligibility 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.

(l) Undue hardship.

1. Undue Hardship shall exist only when:

(i) The individual has been denied LTSS payments due to one of the following reasons.

(I) The value of the homestead property exceeds the home equity limit;

(II) An Estranged Spouse's failure to cooperate with the resource assessment process;

(III) A penalty period is applied due to the transfer of asset provision; or

(IV) The applicant is resource ineligible due to the provisions of a trust, and the applicant is otherwise resource eligible.

(ii) The ineligibility for LTSS payments 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;

(iii) The institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations, and

(iv) 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.

3. An Undue Hardship claim must be filed within ninety (90) days of the Application File Date, or no later than forty (40) days after the date of the denial or termination notice. However, an undue hardship claim can also be filed if an individual experiences a change in circumstances while in a penalty period.

4. TennCare will determine whether Undue Hardship exists and notify the Applicant within thirty (30) days of filing.

5. If Undue Hardship is determined not to exist, the denial of Undue Hardship may be appealed within forty (40) days.

(m) Patient Liability. Individuals determined eligible for institutional services 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. Patient liability is calculated based on total income remaining after deductions in accordance with 42 C.F.R. § 435.725, 42 C.F.R. § 435.726, and the State Plan. Total income includes all amounts of income available to an individual from all sources, which are considered to be income for

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eligibility purposes, unless specifically excluded from post-eligibility under the State Plan or based on other Federal laws.

1. Post-Eligibility Treatment of Certain Payments from the Department of Veterans Affairs. VA improved pensions limited to $90 per month are not considered in the post-eligibility process. If an unmarried, childless veteran or the surviving, childless spouse of a veteran is in a state veterans home and receives a VA pension that exceeds $90 per month, the VA pension, including any payment made for aid and attendance or for unreimbursed medical expenses, is counted in total income and applied to the state veterans home's cost of providing nursing home care to the veteran or surviving spouse.

2. Patient liability is determined by allowing the following deductions from an individual's total income:

   (i) A Personal Needs Allowance (PNA) for clothing and other personal needs while receiving Institutional Eligibility. Apply the appropriate PNA based on the type of long term services and supports the individual receives, as follows:

      (I) Nursing Facility. Through December 31, 2024, subtract $50.00 PNA from the gross income of an individual in a nursing facility or ICF/IID. Effective January 1, 2025, subtract $70.00 PNA from the gross income of an individual in a nursing facility or ICF/IID. For an individual with greater need who participates in a sheltered workshop, subtract up to $100 of earnings plus the PNA.

      (II) Individuals receiving HCBS through CHOICES, ECF CHOICES, or a 1915(c) waiver, and PACE participants: PNA is three hundred percent (300%) 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 C.F.R. §§ 435.725(c)(4) and 726(c)(4).

3. Community Spouse Income Maintenance Allowance (CSIMA). When determining an institutionalized individual's patient liability, an allowance is deducted from his 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 Eligibility, unless one spouse is receiving HCBS.

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(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 poverty level standard used to determine the community spouse's monthly maintenance needs. The SMA is 150% of the FPL for a household of 2. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

(II) Maintenance Needs Standard: The minimum amount of monthly income necessary to meet the community spouse's maintenance needs and prevent impoverishment. The Maintenance Needs Standard is determined by adding the SMA and the Excess Shelter Allowance (ESA). 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 thirty percent (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.

4. Dependent Income Maintenance Allowance (DIMA): When determining patient liability, an allowance is deducted from the individual's income for the needs of his dependents living at home.

(i) Dependent relatives include the individual's or the spouse's adult dependent children, parents, siblings, and minor children who are living at home.

(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 DIMA for each additional dependent family member living with the community spouse is equal to one-third of the difference between the SMA and the dependent's gross income.

(v) DIMA Calculation: The dependent allocation(s) equals the SMA for the community spouse minus the dependent's own gross countable income divided by 3.

(vi) The DIMA for dependent relatives living in the home without a community spouse is determined based on the MNIS.

(vii) DIMA Calculation: The dependent allocation is the MNIS for the household size if the total net countable income of the dependent(s) is less than the MNIS. No dependent allocation is given if the total net countable income of the dependent(s) is more than the MNIS for the household size.

5. Incurred Medical Expenses: Expenses for medical or remedial care not subject to third party payment as defined at 42 C.F.R. §§ 435.725(c)(4), 435.726(c)(4) and 435.832, and outlined in the State Plan are allowable deductions. Criteria for Deduction of an Incurred Medical Expense:

(i) The expense must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, the individual's spouse or family or medical trust fund, Medicare, etc.

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(ii) The expense may be unpaid or paid by the individual during the month(s) of eligibility determination or paid by a member of the individual'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 individual is legally liable.

(v) Medical expenses incurred during a period of ineligibility and up to three months prior to the month of application may be allowable medical expenses.

(vi) Deductions will be allowed in compliance with 42 C.F.R. §§ 435.725(c)(4), 435.726(c)(4), and 435.832, and the State Plan.

(n) 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 to be used for her own needs. The resource assessment is a snapshot of all countable assets owned by the couple at the time of the first period of continuous confinement but conducted upon application or when an assessment is requested prior to application. For applicants in a Medical Institution, it is a snapshot of the couple's assets on the date of admission to a Medical Institution. For HCBS applicants, it is a snapshot on the effective date of the approved Pre-Admission Evaluation (PAE). If an application for HCBS is filed before a PAE has been approved, and the PAE is approved within 90 days of application, the snapshot date for the resource assessment is the Application File Date. 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 first continuous period of institutionalization.

(iii) For residents in a Medical Institution, an assessment remains in effect until a TennCare application is filed, regardless of any interruptions in confinement. For HCBS, the effective date of the earliest approved PAE should be used to conduct the resource assessment, as long as the individual continues to meet the medical level of care at the time an application for HCBS is filed. 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 CSRMA 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

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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 an 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 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 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 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 TennCare 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, 42 U.S.C. § 1396r-5(e)(2)(A). Revisions to the spousal allowance of resources can be made by an Administrative Judge or by court order.

(II) CSRMA Revisions. The amount of the CSRMA may only be revised by an Administrative Judge or by court order, and only if additional verification/documentation is provided. The CSRMA may only be revised when:

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I. The initial assessment was alleged to be incorrect and the Administrative Judge confirms the allegations;

II. An Administrative Judge determines a larger CSRMA is necessary to raise the community spouse's available income to the Maintenance Needs Standard or to an amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income; or

III. A court order is received against an institutionalized spouse for the support of the community spouse and resources are transferred pursuant to the court order.

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

I. When Additional Resources May be Allocated to Community Spouse: In the event that the institutionalized spouse does not have enough income to provide the community spouse with sufficient income to meet the Maintenance Needs Standard and the CSRMA is not enough to offset the income shortfall, additional resources may be allocated to the community spouse by an Administrative Judge if the couple has additional resources above the community spouse's protected amount (CSRMA).

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. TennCare uses the Single Fixed Annuity model to address appeals when there is insufficient income to provide the community spouse with the Maintenance Needs Standard 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 TennCare eligibility appeals process to make up any shortfall between the amount of income allocated from the institutional spouse to the community spouse and the Maintenance Needs Standard, 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 Maintenance Needs Standard, 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 TennCare.

(C) Additional Resources may be allocated to the community spouse if the amount of resources needed to cover the shortfall is greater than the CSRMA.

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. 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.

E. The amount of additional resources that are necessary to cover the shortfall 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 FMV is not considered to have occurred when resources are transferred from the institutionalized individual to the community spouse or vice versa according to a completed resource assessment.

(II) Should the spouse who received the allocation according to the resource assessment then transfer the resource to someone else for less than FMV, the transfer will not be treated as a transfer of assets since the resources of a couple are treated separately after the establishment of Institutional Medicaid eligibility.

(III) Transfer of assets for less than FMV 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) ECF CHOICES Demonstration Groups.

(a) ECF CHOICES 217-Like Group.

1. Definition: See Rule .02.

2. Technical Eligibility Requirements: See Rule .04.

3. Special Eligibility Requirements: To gain eligibility in this category, applicants must:

(Rule 1200-13-20-.08, continued)

(i) Have an Intellectual Disability manifested before eighteen (18) years of age or a Developmental Disability manifested before twenty-two (22) years of age, as specified in T.C.A. § 33-1-101.

(ii) Be in one of the defined target populations specified in Chapter 1200-13-01-.31.

(iii) Meet Nursing Facility Level of Care (NF LOC), as defined in Chapter 1200-13-01-.02.

(iv) Qualify for an available slot in an ECF CHOICES Group defined at 1200-13-01-.02(56) for which enrollment is currently open, or for an available reserve capacity slot, in accordance with Chapter 1200-13-01-.31.

(v) Receive ECF CHOICES.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual. Parent-to-child deeming rules shall apply for a child except for those age 17 or older who meet institutional level of care, those enrolled prior to November 23, 2020, those who will be enrolled in ECF CHOICES Group 7 (Intensive Behavioral Family Supports), and those transitioning from ECF CHOICES Group 7 to ECF CHOICES Group 4 (Essential Family Supports) as defined in TennCare 1115 Demonstration Waiver III.

6. Resource Limitations: Resources shall not exceed $2,000.00 for an individual. Parent-to-child deeming rules shall apply for a child except for those age 17 or older who meet institutional level of care, those enrolled prior to November 23, 2020, those who will be enrolled in ECF CHOICES Group 7 (Intensive Behavioral Family Supports), and those transitioning from ECF CHOICES Group 7 to ECF CHOICES Group 4 (Essential Family Supports) as defined in TennCare 1115 Demonstration Waiver III.

7. Effective Date: Eligibility begins on the date all eligibility requirements are met.

8. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

9. Special Asset Rules: See Paragraph (5)(i).

10. Transfer of Assets: See Paragraph (5)(j).

11. Penalty for Transfer of Assets: See Paragraph (5)(k).

12. Undue Hardship: See Paragraph (5)(l).

13. Patient Liability: See Paragraph (5)(m).

14. Resource Assessment and CSRMA: See Paragraph (5)(n).

(b) Interim ECF CHOICES At-Risk Group.

1. Definition: See Rule .02.

(Rule 1200-13-20-.08, continued)

2. Technical Eligibility Requirements: See Rule .04.

3. Special Eligibility Requirements: To gain eligibility in this category, applicants must:

   (i) Not otherwise be eligible in a TennCare Medicaid category that confers LTSS benefits.

   (ii) Have an Intellectual Disability manifested before eighteen (18) years of age or a developmental disability manifested before twenty-two (22) years of age, as specified in T.C.A. § 33-1-101.

   (iii) Be in one of the defined target populations specified in Chapter 1200-13-01-.31.

   (iv) Be At-Risk for Institutionalization, as defined in Chapter 1200-13-01-.02.

   (v) Qualify for an available slot in an ECF CHOICES Group defined at 1200-13-01-.02(56) for which enrollment is currently open, or for an available reserve capacity slot, in accordance with Chapter 1200-13-01-.31.

   (vi) Receive ECF CHOICES.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual. Parent-to-child deeming rules shall apply.

6. Resource Limitations: Resources shall not exceed $2,000.00 for an individual. Parent-to-child deeming rules shall apply.

7. Effective Date: Eligibility begins on the date all eligibility requirements are met.

8. New enrollment into the Interim ECF CHOICES At-Risk Group closed upon implementation of Phase 2 of ECF CHOICES. Individuals enrolled in the Interim ECF CHOICES At-Risk Group prior to implementation of Phase 2 may remain enrolled in the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group.

9. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

10. Special Asset Rules: See Paragraph (5)(i).

11. Transfer of Assets: See Paragraph (5)(j).

12. Penalty for Transfer of Assets: See Paragraph (5)(k).

13. Undue Hardship: See Paragraph (5)(l).

14. Patient Liability: See Paragraph (5)(m).

15. Resource Assessment and CSRMA: See Paragraph (5)(n).

(Rule 1200-13-20-.08, continued)

(c) ECF CHOICES At-Risk Group.

1. Definition: See Rule .02.

2. Technical Eligibility Requirements: See Rule .04.

3. Special Eligibility Requirements: To gain eligibility in this category, applicants must:

(i) Not otherwise be eligible in a Medicaid category that confers LTSS benefits.

(ii) Have an Intellectual Disability manifested before eighteen (18) years of age or a developmental disability manifested before twenty-two (22) years of age, as specified in T.C.A. § 33-1-101.

(iii) Be in one of the defined target populations specified in Chapter 1200-13-01-.31.

(iv) Be At-Risk for Institutionalization, as defined in Chapter 1200-13-01-.02.

(v) Qualify for an available slot in an ECF CHOICES Group defined at 1200-13-01-.02(56) for which enrollment is currently open, or for an available reserve capacity slot, in accordance with Chapter 1200-13-01-.31.

(vi) Receive ECF CHOICES.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Income must be at or below 150% of the FPL for an individual. Parent-to-child deeming rules shall apply.

6. Resource Limitations: Resources shall not exceed $2,000.00 for an individual. Parent-to-child deeming rules shall apply.

7. Effective Date: Eligibility begins on the date all eligibility criteria are met.

8. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

9. Special Asset Rules: See Paragraph (5)(i).

10. Transfer of Assets: See Paragraph (5)(j).

11. Penalty for Transfer of Assets: See Paragraph (5)(k).

12. Undue Hardship: See Paragraph (5)(l).

13. Patient Liability: See Paragraph (5)(m).

14. Resource Assessment and CSRMA: See Paragraph (5)(n).

(d) ECF CHOICES Working Disabled Group.

(Rule 1200-13-20-.08, continued)

1. Definition: See Rule .02.

2. Technical Eligibility Requirements: See Rule .04.

3. Special Eligibility Requirements: To gain eligibility in this category, applicants must:

   (i) Not otherwise be eligible in a TennCare Medicaid category that confers LTSS benefits.

   (ii) Have an Intellectual Disability manifested before eighteen (18) years of age or a Developmental Disability manifested before twenty-two (22) years of age, as specified in T.C.A. § 33-1-101.

   (iii) Be in one of the defined target populations specified in Chapter 1200-13-01-.31.

   (iv) Meet Nursing Facility Level of Care (NF LOC) or be At Risk for Institutionalization, as defined in Chapter 1200-13-01-.02.

   (v) Be working and would be eligible for SSI if their Earned Income was disregarded.

   (vi) Qualify for an available slot in an ECF CHOICES Group defined at 1200-13-01-.02(56) for which enrollment is currently open, or for an available reserve capacity slot, in accordance with Chapter 1200-13-01-.31.

   (vii) Receive ECF CHOICES.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Two separate income tests apply:

   (i) Income must be at or below 250% of the FPL for an individual. Parent-to-child deeming rules shall apply for a child except for those age 17 or older who meet institutional level of care, those enrolled prior to November 23, 2020, those who will be enrolled in ECF CHOICES Group 7 (Intensive Behavioral Family Supports), and those transitioning from ECF CHOICES Group 7 to ECF CHOICES Group 4 (Essential Family Supports) as defined in TennCare 1115 Demonstration Waiver III.

   (ii) Income must be less than the SSI Federal Benefit Rate after the applicant's earned income is disregarded.

      (I) Parent-to-child deeming rules and spouse-to-spouse deeming rules shall apply.

      (II) When spouse-to-spouse income deeming occurs, the applicant's income is compared against the SSI Federal Benefit Rate for a couple.

6. Resource Limitations: Resources shall not exceed $2,000.00 for an individual. Parent-to-child deeming rules shall apply for a child except for those age 17 or older who meet institutional level of care, those enrolled prior to November 23, 2020, those who will be enrolled in ECF CHOICES Group 7 (Intensive Behavioral Family Supports), and those transitioning from ECF CHOICES Group 7 to ECF

(Rule 1200-13-20-.08, continued)

CHOICES Group 4 (Essential Family Supports) as defined in TennCare 1115 Demonstration Waiver III.

7. Effective Date: Eligibility begins on the date all eligibility criteria are met.

8. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

9. Special Asset Rules: See Paragraph (5)(i).

10. Transfer of Assets: See Paragraph (5)(j).

11. Penalty for Transfer of Assets: See Paragraph (5)(k).

12. Undue Hardship: See Paragraph (5)(l).

13. Patient Liability: See Paragraph (5)(m).

14. Resource Assessment and CSRMA: See Paragraph (5)(n).

(7) Medicare Savings Programs.

(a) QMB.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QMB is eligible for TennCare Buy-in of his Medicare premiums, and payment of Medicare coinsurance and deductibles.

3. Technical Requirements: See Rule .04.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: At or below one hundred percent (100%) of the FPL.

6. Resource Limitations: Limits for an individual and couple as determined by CMS.

7. Effective Date: First day of the month following the month in which the application is approved.

(b) SLMB.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for SLMB is eligible for TennCare Buy-in of his Medicare Part B premiums.

3. Technical Requirements: See Rule .04.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Over one hundred percent (100%) but less than one hundred twenty percent (120%) of the FPL.

(Rule 1200-13-20-.08, continued)

6. Resource Limitations: Limits for an individual and couple as determined by CMS.

7. Effective Date: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(c) QI1.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QI1 is eligible for TennCare Buy-in of his Medicare Part B premiums, pursuant to State allocation of federal funds. The individual may not be receiving TennCare Medicaid.

3. Technical Requirements: See Rule .04.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Over one hundred twenty percent (120%) but less than one hundred thirty-five percent (135%) of FPL.

6. Resource Limitations: Limits for an individual and couple as determined by CMS.

7. Effective Date: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(d) QDWI.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QDWI is eligible for TennCare Buy-in of his Medicare Part A premiums, but not for Part B premiums.

3. Technical Requirements: See Rule .04.

4. Special Eligibility Requirements: An individual must be under age sixty-five (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 Rule .06.

6. Income Limitations: Two hundred percent (200%) of FPL.

7. Resource Limitations: Resources not exceeding twice the maximum for SSI for an individual or a couple, as applicable.

8. Effective Date: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(8) Other.

(a) Medically Needy Children and Pregnant Women.

(Rule 1200-13-20-.08, continued)

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .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 twenty-one (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 spenddown obligation as outlined in the State Plan. See Rule .06.

6. Resource Limitations: Medically Needy applicants are permitted to retain resources not to exceed $2,000.00 for an individual, $3,000.00 for two individuals and an additional $100.00 is added per additional individual. See Rule .06.

7. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

8. Other: An individual in this category may receive Continuous Eligibility if the individual is a Pregnant Woman. See Rule .09.

(b) Breast and Cervical Cancer Category of Eligibility.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04.

3. Special Eligibility Requirements:

(i) Individuals must be younger than age sixty-five (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, the applicant will be considered to no longer have health insurance.

(ii) Individuals must first be screened and approved by the Department of Health's BCSP.

(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 BCSP.

5. Resource Limitations: None.

(Rule 1200-13-20-.08, continued)

6. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

7. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(c) Presumptive Breast or Cervical Cancer.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .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 sixty-five (65) and must lack 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 BCSP 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 .02.

2. Technical Requirements: See Rule .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) TennCare Pregnant Women; 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

(Rule 1200-13-20-.08, continued)

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 C.F.R. § 440.255. Only the services involved in the emergency itself will be reimbursed and coverage is only provided for the single episode of care.

(9) Katie Beckett Program-related Eligibility Groups.

(a) Katie Beckett Group Part A.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04.

3. Special Eligibility Requirements:

(i) Individual must be younger than eighteen (18) years of age.

(ii) Individual must meet the medical level of care requirements according to Rule 1200-13-01-.11.

(iii) Individual must not be financially eligible for any other category of TennCare Medicaid or TennCare Standard.

(iv) Third Party Liability (TPL).

(I) Katie Beckett Group Part A enrollees shall be covered by either employer-sponsored insurance or private insurance, at all times. The employer-sponsored insurance or private insurance plans must include minimum essential coverage, as defined by 45 CFR 156.110(a).

(Rule 1200-13-20-.08, continued)

(II) If an eligible child attests to having TPL at the time of application, a notice requesting proof of TPL and the amount of the monthly TPL premium will be sent to the child. The child will have twenty (20) days from the date of the notice requesting proof of TPL and the amount of monthly TPL premiums to provide the requested information. If the requested information is not provided in a timely manner, the application will be denied for failure to respond.

(III) If an eligible child does not have TPL at the time of application, the child will be enrolled in Katie Beckett Group Part A and will be required to submit proof of TPL and the amount of the monthly TPL premiums.

I. The timeline for submitting proof of TPL will be as follows:

A. Katie Beckett Group Part A enrollees who are enrolled on or before October 1 will have until January 15 of the immediately following calendar year to submit proof of TPL.

B. Katie Beckett Group Part A enrollees who are enrolled between October 2 and December 31 will have until January 15 of the second following calendar year to submit proof of TPL.

II. Failure to timely submit proof of TPL.

A. Enrollees who fail to submit proof of TPL in accordance with the timelines provided in Subitem I. will receive an ex parte review of eligibility for other categories of TennCare Medicaid.

B. If the ex parte review does not result in enrollment in another category of eligibility, the enrollee will be sent a questionnaire to determine if the enrollee's circumstances have changed since the last review that would result in eligibility for other categories of TennCare Medicaid. The questionnaire must be returned within twenty (20) days from the date of the questionnaire.

C. If the enrollee does not timely return the questionnaire or if the answers provided on the questionnaire do not result in enrollment in another category of eligibility, the enrollee will be sent a notice of termination informing the enrollee that Katie Beckett Group Part A coverage will be terminated twenty (20) days from the date of the termination notice if proof of TPL is not submitted prior to the date of termination.

(IV) Calculating an eligible child's portion of monthly TPL premiums.

I. The eligible child's portion of the family's monthly TPL premium is calculated by dividing the total amount of the family's monthly TPL premium by the number of individuals covered by the TPL.

II. If a parent of the eligible child is required to purchase TPL in order for the eligible child to have TPL coverage, the parent's portion of the monthly TPL premium will be included in the child's portion of the TPL when calculating the Katie Beckett Group Part A premium.

(V) Katie Beckett Group Part A enrollees must report any changes in TPL within ten (10) days of the change. Changes in TPL that must be reported include, but are not limited to:

I. Loss of TPL;

II. Change of TPL provider; or

III. Change in monthly TPL premium.

(VI) Loss of TPL.

I. If a Katie Beckett Group Part A enrollee loses TPL coverage and notifies TennCare, the enrollee will receive a notice requiring proof of new TPL. The enrollee will have sixty (60) days from the date of notice to submit proof of the new TPL.

II. If the enrollee does not submit proof of TPL within 60 days of the date of the notice, the enrollee will be sent a questionnaire to determine if the enrollee's circumstances have changed since the last review that would result in eligibility for other categories of TennCare Medicaid. The questionnaire must be returned within twenty (20) days from the date of the questionnaire.

III. If the enrollee does not timely return the questionnaire or if the answers provided on the questionnaire do not result in enrollment in another category of eligibility, the enrollee will be sent a notice of termination informing the enrollee that Katie Beckett Group Part A benefits will be terminated twenty (20) days from the date of the termination notice if proof of the new TPL is not submitted prior to the date of termination.

(VII) A Katie Beckett Group Part A enrollee who did not have TPL at the time of application and is disenrolled from Katie Beckett Group Part A for failing to timely submit proof of TPL will be eligible to transition to Medicaid Diversion Group Part B if a Medicaid Diversion Group Part B slot is available.

(VIII) Katie Beckett Group Part A Hardship Exception for Assistance with Premium Payments.

I. If an eligible child applying for Katie Beckett Group Part A does not have TPL at the time of enrollment, the child may request assistance with premium payments through a hardship exception if the following hardship exception requirements are met:

(Rule 1200-13-20-.08, continued)

A. The cost of the eligible child's portion of all available employer-sponsored or private insurance exceeds five percent (5%) of the family's household income according to MAGI methodology; or

B. The child's household income is less than four hundred percent (400%) of the FPL according to MAGI methodology and neither of the child's parents have access to employer-sponsored insurance.

II. A hardship exception for assistance with premium payments shall not be available for an eligible child who has TPL at the time of enrollment, even if such coverage is later lost and new TPL coverage must be obtained.

III. Assistance with premium payments is limited to the lesser of the amount by which the child's portion of the family's monthly TPL premium exceeds the child's Katie Beckett Group Part A premium, as detailed below, or the lowest cost silver level child only plan in the highest rating region in Tennessee offered through the Federally Facilitated Marketplace. The amount of TPL premium assistance may be appealed within forty (40) days of the date of the notice.

IV. Assistance with premium payments will begin on the date the hardship exception is approved or on the date the eligible child enrolls in TPL and the initial TPL premium has been paid, whichever is later. The effective date of premium assistance may be appealed within forty (40) days of the date of the hardship exception approval notice.

V. The denial of a request for a hardship exception for assistance with premium payments may be appealed within forty (40) days of the date of the denial notice.

VI. The loss of assistance with premium payments resulting from a change in an enrollee's TPL may be appealed within forty (40) days of the date of the assistance with premium payments termination notice. If the termination of assistance with premium payments is appealed within twenty (20) days, the assistance with premium payments will continue until the conclusion of the appeal process.

(v) Katie Beckett Group Part A Premiums.

(I) Households with income above one hundred fifty percent (150%) of the FPL according to MAGI methodology will be required to pay a monthly premium through automatic electronic bank drafts. The amount of the premium will be based on a sliding scale. As set out in the table below, the family's FPL percentage is determined based on their household income and household size according to MAGI methodology, and the amount of the monthly premium for each applicable FPL range is set to the percentage of the income of a household size of two.

(Rule 1200-13-20-.08, continued)

| Household Income (MAGI) | Premium % of income for a household size of two | Monthly Premium |
|---|---|---|
| > 150% - 250% FPL | 1.5% | $25 |
| > 250% - 300% FPL | 2.5% | $75 |
| > 300% - 400% FPL | 3% | $125 |
| > 400% - 500 % FPL | 4% | $225 |
| > 500% FPL - No limit | 5% | $350 + $70 for every 100% above 500% FPL |

(II) Katie Beckett Group Part A premiums, as described in the above table, will be reduced by the costs associated with the eligible child's portion of the family's monthly TPL premiums. If the total amount of the eligible child's portion of the family's TPL premium is more than the eligible child's monthly Katie Beckett Group Part A premium, the child will not have Katie Beckett Group Part A premium obligations. See Subpart (iv) above for calculating the eligible child's portion of the family's monthly TPL premium payment.

(III) Initial enrollment shall not occur until the first month's Katie Beckett Group Part A premium has been paid in full and electronic automatic bank draft arrangements have been made for subsequent months unless the eligible child is not required to pay the monthly Katie Beckett Group Part A premium.

(IV) If the first month's Katie Beckett Group Part A premium is not paid in full within sixty (60) days of the date of the notice detailing the amount of the monthly premium obligation, the application will be denied.

I. If a timely appeal is filed, the Katie Beckett Group Part A program slot will be held until the conclusion of the appeal process.

II. If a timely appeal is not filed, the Katie Beckett Group Part A program slot will be released and a new application for Katie Beckett Group Part A will be required.

(V) Continuous enrollment in Katie Beckett Group Part A is contingent on timely payments of the monthly Katie Beckett Group Part A premium unless the eligible child does not have Katie Beckett Group Part A premium obligations.

(VI) If a Katie Beckett Group Part A enrollee is required to pay Katie Beckett Group Part A premiums after previously not having Katie Beckett Group Part A premium obligations, the enrollee will have sixty (60) days from the date of the notice detailing the amount of the monthly premium obligation to pay the first month's Katie Beckett Group Part A premium in full and set up electronic automatic bank draft arrangements.

(VII) Once enrolled, if the Katie Beckett Group Part A premium payment is more than thirty (30) days in arrears, enrollees will be sent a notice of suspension informing the enrollee that Katie Beckett Group Part A benefits will be suspended twenty (20) days from the date of the

(Rule 1200-13-20-.08, continued)

suspension notice if premium payments are not paid in full prior to the date of suspension. If suspended, Katie Beckett Group Part A program benefits will return to active status retroactive to the date they were suspended if:

I. Past due premium payments are paid in full while the enrollee is in suspended status; or

II. Benefits were suspended as the result of administrative error.

(VIII) If any part of a Katie Beckett Group Part A premium payment is more than sixty (60) days in arrears, enrollees will be sent a notice of termination informing the enrollee that Katie Beckett Group Part A benefits will be terminated twenty (20) days from the date of the termination notice if past due Katie Beckett Group Part A premium payments are not paid in full prior to the date of termination. If the outstanding premium amounts owed are paid in full at any point prior to the effective date of termination, program benefits will return to active status retroactive to the date they were suspended. A Katie Beckett Group Part A enrollee who is terminated from Katie Beckett Group Part A for failing to pay the monthly Katie Beckett Group Part A premium will be eligible to transition to Medicaid Diversion Group Part B if a Medicaid Diversion Group Part B slot is available.

(IX) Once enrolled in Katie Beckett Group Part A, increases in the household income of an enrollee for Katie Beckett Group Part A premium purposes will not need to be reported until the annual renewal process in accordance with Rule .09. Enrollee income changes must be reported within ten (10) days of the occurrence in accordance with Rule .03(2)(a).

(X) If a Katie Beckett Group Part A enrollee reports a change in the household income that results in a change in the Katie Beckett Group Part A premium, the enrollee will receive a notice informing the enrollee of the new Katie Beckett Group Part A premium payment amount.

(vi) Eligibility and enrollment into Katie Beckett Group Part A is contingent upon a slot being available in accordance with Chapter 1200-13-01.

4. Eligibility will be based upon a household size of one (1).

5. Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual. Parent-to-child deeming rules shall not apply.

6. Resource Limitations: Resources shall not exceed two thousand dollars ($2,000.00) for an individual. Parent-to-child deeming rules shall not apply.

7. Effective Date of Eligibility: Eligibility begins on the date that the first month’s Katie Beckett Group Part A premium is paid in full and electronic automatic bank draft arrangements have been made for subsequent months. If an eligible child is not required to pay Katie Beckett Group Part A premiums, eligibility begins on the date the individual is determined to be eligible.

(Rule 1200-13-20-.08, continued)

8. Upon turning age eighteen (18), individuals enrolled in Katie Beckett Group Part A may remain enrolled in Katie Beckett Group Part A for up to twelve (12) months following the enrollee's eighteenth (18th) birthday if an application for SSI is pending or in appeal status.

9. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

(b) Medicaid Diversion Group Part B.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04.

3. Special Eligibility Requirements:

(i) Individual must be younger than eighteen (18) years of age.

(ii) Individual must meet the medical level of care requirements according to Rule 1200-13-01-.11.

(iii) Individual must not be financially eligible for any other category of TennCare.

(iv) Eligibility and enrollment into Medicaid Diversion Group Part B is contingent upon a slot being available in accordance with Chapter 1200-13-01.

4. Eligibility will be based upon a household size of one (1).

5. Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual. Parent-to-child deeming rules shall not apply.

6. Resource Limitations: Resources shall not exceed two thousand dollars ($2,000.00) for an individual. Parent-to-child deeming rules shall not apply.

7. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

8. Medicaid Diversion Group Part B will be administered by the Department of Intellectual and Developmental Disabilities (DIDD).

(c) Continued Eligibility Group Part C.

1. Definition: See Rule .02

2. Technical Requirements: See Rule .04

3. Special Eligibility Requirements:

(i) Individual who was validly enrolled in TennCare Medicaid and is losing eligibility for TennCare Medicaid and who is younger than eighteen (18) years of age.

(Rule 1200-13-20-.08, continued)

(ii) Individual must meet the medical level of care requirements according to Rule 1200-13-01-.11.

(iii) Individual would be eligible to enroll in Katie Beckett Group Part A if a Katie Beckett Group Part A slot was available.

(iv) No Katie Beckett Group Part A slots are available.

4. Eligibility will be based upon a household size of one (1).

5. Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual. Parent-to-child deeming rules shall not apply.

6. Resource Limitations: Resources shall not exceed $2,000.00 for an individual. Parent-to-child deeming rules shall not apply.

7. If an enrollee is terminated from the Continued Eligibility Group Part C, the individual will have to reapply for Katie Beckett Group Part A with enrollment in Katie Beckett Group Part A being limited to slot availability.

8. If an enrollee is terminated from the Continued Eligibility Group Part C because of an administrative error, the individual will be eligible to re-enroll in the Continued Eligibility Group Part C.

9. Upon turning age eighteen (18), Continued Eligibility Group Part C enrollees may remain enrolled in the Continued Eligibility Group Part C for up to twelve (12) months following the eighteenth (18th) birthday if an application for SSI is pending or in appeal status.

10. Other: An individual in this category may receive Continuous Eligibility if the individual is a child under age nineteen (19) or a Pregnant Woman. See Rule .09.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-117, 71-5-134, 71-5-147, and 71-5-164; TennCare II/III Section 1115(a) Medicaid Demonstration Waiver Extension; and TennCare III Section 1115(a) Medicaid Demonstration Waiver* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendments filed May 24, 2019; effective August 22, 2019. Emergency rules filed November 20, 2020; effective through May 19, 2021. Amendments filed February 17, 2021; effective May 18, 2021. Amendments filed May 13, 2022; effective August 11, 2022. Amendments filed August 25, 2025; effective November 23, 2025.*

**1200-13-20-.09 REDETERMINATION AND TERMINATION.**

(1) Redetermination of eligibility for TennCare Medical Assistance.

(a) Redetermination or renewal is the process of verifying whether an enrollee continues to meet the eligibility requirements of a particular TennCare program.

(b) An enrollee must have eligibility redetermined once every twelve (12) months, and no more frequently than once every twelve (12) months according to 42 C.F.R. § 435.916, absent a waiver from CMS.

(Rule 1200-13-20-.09, continued)

(c) 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 TennCare for eligibility in all other categories prior to termination.

(d) An enrollee's TennCare Medical Assistance eligibility shall be redetermined as required by the appropriate category of Medical Assistance as described in this Rule, unless otherwise agreed to by the Single State Agency and CMS. Prior to the termination of TennCare Medical Assistance eligibility, eligibility will be redetermined according to the following process:

1. TennCare will redetermine eligibility prior to the expiration of the enrollee's current eligibility period.

2. TennCare will complete an ex parte review of eligibility. A renewal packet will be issued when ex parte review does not result in a finding of eligibility. TennCare Medical Assistance 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 TennCare. The mail date will be the date on the notice. The enrollee may provide information by the same modes permitted for filing an application specified at Rule .05, or as otherwise agreed to by the Single State Agency and CMS.

3. TennCare will provide assistance with submitting a renewal form according to Rule .05.

4. TennCare will use the individual's responses in the renewal packet to complete redetermination. TennCare 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 TennCare is able to renew eligibility in a TennCare Medical Assistance category based on information known to TennCare, or information provided in the renewal packet, and requested verifications, the agency will notify the enrollee and enroll him in the 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 Medical Assistance category) while TennCare reviews their eligibility for open Medical Assistance categories. If TennCare determines that the enrollee is eligible for a TennCare Medical Assistance category, the agency will notify the individual as follows:

(i) If TennCare 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. If the individual is enrolled in a different TennCare Medicaid category of eligibility, the previous category will be closed with no further notice to the enrollee.

(ii) If TennCare 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 TennCare 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.

(iv) If TennCare determines that the enrollee is eligible for MSP, the agency will notify the enrollee and he will be enrolled into the appropriate MSP. If an individual is determined eligible for MSP and ineligible for TennCare Medicaid, notification of enrollment in an MSP will include notification of the denial of TennCare Medicaid. Notification of enrollment into SLMB or QI1 will include notification of the denial of QMB eligibility.

7. If an enrollee provides some but not all of the necessary information to TennCare to determine his eligibility for open Medical Assistance categories during the forty (40) day period following the mailing of the renewal packet, TennCare 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 twenty (20) days from the date of the termination notice.

9. If TennCare makes a determination that the enrollee is not eligible for any open Medical Assistance categories, the enrollee will be sent a notice of termination informing the enrollee that coverage will be terminated twenty (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 while TennCare 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 ninety (90) days after termination of eligibility. Renewal packets or additional information received during the ninety (90) day reconsideration period will be processed without requiring a new application. Individuals terminated for failure to respond and subsequently determined eligible during the ninety (90) day reconsideration period will have eligibility reinstated as of the date of termination, except for those determined eligible for QMB (whose effective date will be the first day of the month after the QMB approval).

(e) An individual who has been determined eligible for TennCare Medicaid under the rules for BCC shall annually recertify eligibility in terms of continuation of active treatment, address, and access to health insurance. If the individual is found to no longer be eligible through this review, the individual will be reviewed using the redetermination process set forth in this paragraph.

(f) An individual who has been determined eligible for TennCare under the rules for Katie Beckett Group Part A, Medicaid Diversion Group Part B, or Continued Eligibility Group Part C will be required to verify continued eligibility annually. If the individual is found to no longer be eligible through this review, the individual will be reviewed using the redetermination process set forth in this paragraph.

(g) Consistent with 42 C.F.R. § 435.919, TennCare must promptly redetermine eligibility between regular renewals of eligibility whenever it receives information about a change in an enrollee's circumstances that may affect eligibility.

(h) Continuous Eligibility for Children Under Age 19. Consistent with 42 C.F.R. § 435.926, Continuous Eligibility is provided to children under the age of 19 enrolled in TennCare Medicaid, in TennCare Standard, or in CoverKids, regardless of changes in circumstance, except for children enrolled in the following: a Medically Needy category, the IE Foster Care category, Transitional Medicaid, Extended Medicaid, or Katie Beckett Medicaid Diversion Group Part B. The Continuous Eligibility period begins on the effective date of the child's most recent determination or Redetermination of eligibility and ends the last day of the month that the child turns age nineteen (19) or the end of a twelve (12) month period of Continuous Eligibility, whichever is earlier. The following are exceptions to Continuous Eligibility for children under the age nineteen (19):

1. The enrollee dies.

2. The enrollee or the enrollee's representative voluntarily requests a termination of the child's coverage.

3. The enrollee ceases to be a Tennessee resident.

4. TennCare determines that eligibility was determined incorrectly at the most recent determination or Redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the enrollee or the enrollee's representative.

5. The enrollee is age nineteen (19) or over.

(i) Continuous Eligibility for Hospitalized Children. Consistent with 42 C.F.R. § 435.172, children enrolled in the MAGI Infants and Children Under Age 19 category will be provided Continuous Eligibility until the end of an inpatient stay for which inpatient services are covered by TennCare Medicaid if the child is receiving such inpatient services on the date the child turns age nineteen (19), and the child would have remained eligible for this category but for turning age nineteen (19).

(j) Continuous Eligibility for Pregnant Women.

1. Continuous Eligibility for a Sixty (60) Day Postpartum Period.

(i) Women enrolled in CoverKids Pregnant Women while pregnant will be provided Continuous Eligibility through a sixty (60) day postpartum period, beginning on the day pregnancy ends, regardless of changes in circumstance and regardless of how pregnancy ends, even if it has been more than 12 months since the enrollee's last determination of eligibility or Redetermination of eligibility.

(ii) Women who apply and are approved for TennCare Medicaid with an Effective Date of eligibility that is after the end of their pregnancy will be provided Continuous Eligibility through a sixty (60) day postpartum period, beginning on the day pregnancy ends, regardless of changes in circumstance and regardless of how pregnancy ends, even if it has been more than twelve (12) months since the enrollee's last determination of eligibility or Redetermination of eligibility.

(Rule 1200-13-20-.09, continued)

2. Continuous Eligibility for a Twelve (12) Month Postpartum Period. Women enrolled in TennCare Medicaid, TennCare Standard, or CoverKids Children while pregnant (including during a period of retroactive eligibility) will be provided Continuous Eligibility through a twelve (12) month postpartum period, beginning on the day pregnancy ends, regardless of changes in circumstance and regardless of how pregnancy ends, even if it has been more than twelve (12) months since the enrollee's last determination of eligibility or Redetermination of eligibility. An enrollee must remain in the same category of medical assistance she has on the day her pregnancy ends to remain eligible for Continuous Eligibility.

3. The following are exceptions to Continuous Eligibility for Pregnant Women:

(i) The enrollee dies.

(ii) The enrollee or the enrollee's representative voluntarily requests termination of coverage.

(iii) The enrollee ceases to be a Tennessee resident.

(iv) TennCare determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the enrollee or the enrollee's representative.

(k) An individual in a presumptive eligibility period will not receive Continuous Eligibility.

(l) Individuals enrolled in the Institutional Medicaid category, an ECF CHOICES category, or the Katie Beckett Group Part A category may receive Continuous Eligibility for their Medicaid coverage; however, their LTSS-related services may end based on changes in circumstance.

(2) Termination of TennCare Medical Assistance.

(a) TennCare will send termination notices to all enrollees being terminated pursuant to state and federal law who are not determined to be eligible for any open category of Medical Assistance or who receive a change in benefits or services.

(b) Termination notices will be sent twenty (20) days in advance of the date the coverage will be terminated. When an enrollee requests termination, coverage will be terminated two (2) days after the request for termination is received, and a termination notice will be sent on the date coverage is terminated. Termination notices will be sent to the TennCare 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 TennCare in compliance with Chapter 1200-13-19.

(d) TennCare will reconsider eligibility after termination in compliance with 42 C.F.R. § 435.916(a)(3)(iii).

(e) 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.

(Rule 1200-13-20-.09, continued)

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 71-5-102, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-117, 71-5-134, and 71-5-164; TennCare II/III Section 1115(a) Medicaid Demonstration Waiver Extension; and TennCare III Section 1115(a) Medicaid Demonstration Waiver.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendment filed February 12, 2018; effective May 13, 2018. Amendments filed May 24, 2019; effective August 22, 2019. Emergency rules filed November 20, 2020; effective through May 19, 2021. Amendments filed February 17, 2021; effective May 18, 2021. Amendments filed May 13, 2022; effective August 11, 2022. Amendments filed August 25, 2025; effective November 23, 2025.*