

G.O.C. STAFF RULE ABSTRACT

AGENCY: Department of Finance and Administration, Bureau of TennCare

SUBJECT: TennCare Standard; Buprenorphine

STATUTORY AUTHORITY: Tenn. Code Ann., Sections 71-5-105 and 71-5-109

EFFECTIVE DATES: June 24, 2016, through December 21, 2016

FISCAL IMPACT: According to the Bureau, this rule and the similar rule concerning TennCare Medicaid are anticipated to increase state government expenditures for TennCare Medicaid and TennCare Standard by \$4,541,600, of which \$1,590,300 will be state appropriations. The supplemental appropriation for FY16 was included in the Appropriations Act, Public Chapter 758, effective April 21, 2016, which funds the FY17 budget.

STAFF RULE ABSTRACT: The emergency rule restores the fiscal year 2015-2016 budget reduction to the Bureau, which had reduced expenditures for Buprenorphine-containing products for treatment of opiate addiction for persons age 21 and older by imposing a lifetime coverage limit of 732 therapy days. This emergency rule amendment deletes the lifetime coverage limit and permits the Bureau to reinstate medically necessary treatment of opiate addiction for persons age 21 and older utilizing Buprenorphine.

Impact on Local Governments

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

These rules are not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules are being promulgated to restore the fiscal year 2015-2016 budget reduction to the Bureau of TennCare, which had reduced expenditures for Buprenorphine-containing products for treatment of opiate addiction for persons age 21 and older by imposing a lifetime coverage limit of 732 therapy days. This emergency rule amendment deletes the lifetime coverage limit and permits the Bureau to reinstate medically necessary treatment of opiate addiction for persons age 21 and older utilizing Buprenorphine.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The Rules are lawfully adopted by the Bureau of TennCare in accordance with T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by these Rules are the TennCare enrollees, providers, and managed care contractors. The governmental entity most directly affected by these Rules is the Bureau of TennCare, Tennessee Department of Finance and Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rules were approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these rules is anticipated to increase state government expenditures for TennCare Medicaid and TennCare Standard by \$4,541,600, of which \$1,590,300 will be state appropriations. The supplemental appropriation for FY16 was included in the Appropriations Act, Public Chapter 758, effective April 21, 2016, which funds the FY17 budget.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

John G. (Gabe) Roberts
General Counsel

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

John G. (Gabe) Roberts
General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243

(615) 507-6936
gabe.roberts@tn.gov

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

GW10216122

Department of State
Division of Publications
312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower
Nashville, TN 37243
Phone: 615-741-2650
Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 06-19-16
Rule ID(s): 6201
File Date (effective date): 6/24/16
End Effective Date: 12/21/16

Emergency Rule Filing Form

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

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
Address:	Bureau of TennCare 310 Great Circle Road Nashville, TN
Zip:	37243
Phone:	(615) 507-6446
Email:	george.woods@tn.gov

Rule Type:

Emergency Rule

Revision Type (check all that apply):

Amendments

New

Repeal

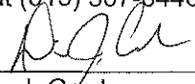
Statement of Necessity:

The Appropriations Act, Public Chapter Number 758, Section 38, Item 4.1, effective April 21, 2016, restores the fiscal year 2015-2016 budget reduction of \$1,586,600.00 to the Bureau of TennCare, which had reduced expenditures for Buprenorphine-containing products for treatment of opiate addiction for persons age 21 and older by imposing a lifetime coverage limit of 732 therapy days. This emergency rule amendment deletes the lifetime coverage limit and permits the Bureau to reinstate medically necessary treatment of opiate addiction for persons age 21 and older utilizing Buprenorphine.

T.C.A. § 4-5-208 permits an agency to adopt an emergency rule when it is required by enactment of the general assembly to implement rules within a prescribed period of time that precludes utilization of rulemaking procedures for promulgation of permanent rules.

Based upon the above information, I have made the finding that the emergency adoption of this rule is required in order to achieve immediate implementation.

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


Darin J. Gordon
Director, Bureau of TennCare
Tennessee Department of Finance and Administration

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

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	Rule Title
1200-13-14-.04	Covered Services
1200-13-14-.10	Exclusions

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

Rule 1200-13-14-.04 Covered Services, Paragraph (1), Subparagraph (c), Part 9 is deleted in its entirety and is replaced with a new Part 9, which shall read as follows:

- 9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:
 - (i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy.
 - (ii) For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant.
 - (iii) At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

Rule 1200-13-14-.10 Exclusions, Paragraph (3), Subparagraph (a), Part 18, Subpart (vii) is amended by inserting the word "and" at the conclusion of Item (I), by deleting and replacing the punctuation at the end of Item (II) with a "." and by deleting Items (III) and (IV) in their entirety as follows:

- (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:
 - (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and
 - (II) Dosage of eight milligrams (8 mg) per day after the sixth (6th) month (183rd day) of therapy.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-14
TENNCARE STANDARD

1200-13-14-.04 COVERED SERVICES.

- (1) Benefits covered under the managed care program
 - (c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

- 9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:
 - (i) ~~Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy. For enrollees who are pregnant while receiving this dosage, the six-month period does not begin until the enrollee is no longer pregnant. At the end of either six month period, the covered dosage amount shall not exceed eight milligrams (8 mg) per day.~~
 - (ii) ~~Therapy shall be limited to a total lifetime period of coverage not to exceed a total of 732 therapy days, which do not have to be consecutive. For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant, on day 732 of treatment, the treatment may continue until the enrollee is no longer pregnant.~~
 - (iii) ~~Effective October 1, 2015, enrollees who have exceeded 549 days of treatment will receive coverage for an additional 183 days of therapy prior to exhaustion of their lifetime coverage limits. At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.~~

1200-13-14-.10 EXCLUSIONS.

- (3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115 waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES program or outside TennCare under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

- (a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21.

18. Certain pharmacy items as follows:

- (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:
- (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and
 - (II) Dosage of eight milligrams (8mg) per day after the sixth (6th) month (183rd day) of therapy; and
 - ~~(III) Total lifetime coverage of 732 therapy days (24 months), which do not have to be consecutive, but if the enrollee is pregnant on day 732 of therapy, treatment may continue until the conclusion of pregnancy; and~~
 - ~~(IV) Effective October 1, 2015, enrollees who have exceeded 549 days (18 months) of therapy will receive coverage for an additional 183 days of therapy prior to exhaustion of their lifetime coverage limits.~~

GW10216131

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

Date: 5/22/2016

Signature: [Handwritten Signature]

Name of Officer: Darin J. Gordon

Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 5/22/2016

Notary Public Signature: [Handwritten Signature]

My commission expires on: 10/18/2016

All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature]
Herbert H. Slatery III
Attorney General and Reporter

6/23/2016
Date

Department of State Use Only

Filed with the Department of State on: 6/24/16

Effective for: 180 *days

Effective through: 12/21/16

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

[Handwritten Signature]
Tre Hargett
Secretary of State

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PUBLICATIONS

G.O.C. STAFF RULE ABSTRACT

AGENCY: Department of Finance and Administration, Bureau of TennCare

SUBJECT: TennCare Medicaid; Buprenorphine

STATUTORY AUTHORITY: Tenn. Code Ann., Sections 71-5-105 and 71-5-109

EFFECTIVE DATES: June 24, 2016, through December 21, 2016

FISCAL IMPACT: According to the Bureau, this rule and the similar rule concerning TennCare Standard are anticipated to increase state government expenditures for TennCare Medicaid and TennCare Standard by \$4,541,600, of which \$1,590,300 will be state appropriations. The supplemental appropriation for FY16 was included in the Appropriations Act, Public Chapter 758, effective April 21, 2016, which funds the FY17 budget.

STAFF RULE ABSTRACT: The emergency rule restores the fiscal year 2015-2016 budget reduction to the Bureau, which had reduced expenditures for Buprenorphine-containing products for treatment of opiate addiction for persons age 21 and older by imposing a lifetime coverage limit of 732 therapy days. This emergency rule amendment deletes the lifetime coverage limit and permits the Bureau to reinstate medically necessary treatment of opiate addiction for persons age 21 and older utilizing Buprenorphine.

Impact on Local Governments

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

These rules are not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules are being promulgated to restore the fiscal year 2015-2016 budget reduction to the Bureau of TennCare, which had reduced expenditures for Buprenorphine-containing products for treatment of opiate addiction for persons age 21 and older by imposing a lifetime coverage limit of 732 therapy days. This emergency rule amendment deletes the lifetime coverage limit and permits the Bureau to reinstate medically necessary treatment of opiate addiction for persons age 21 and older utilizing Buprenorphine.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The Rules are lawfully adopted by the Bureau of TennCare in accordance with T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by these Rules are the TennCare enrollees, providers, and managed care contractors. The governmental entity most directly affected by these Rules is the Bureau of TennCare, Tennessee Department of Finance and Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rules were approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The promulgation of these rules is anticipated to increase state government expenditures for TennCare Medicaid and TennCare Standard by \$4,541,600, of which \$1,590,300 will be state appropriations. The supplemental appropriation for FY16 was included in the Appropriations Act, Public Chapter 758, effective April 21, 2016, which funds the FY17 budget.

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John G. (Gabe) Roberts
General Counsel

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

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General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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Nashville, TN 37243

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gabe.roberts@tn.gov

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

GW10416122

Department of State
Division of Publications
312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower
Nashville, TN 37243
Phone: 615-741-2650
Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 06-20-16
Rule ID(s): 6202
File Date (effective date): 6/24/16
End Effective Date: 12/21/16

Emergency Rule Filing Form

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

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
Address:	Bureau of TennCare 310 Great Circle Road Nashville, TN
Zip:	37243
Phone:	(615) 507-6446
Email:	george.woods@tn.gov

Rule Type:

Emergency Rule

Revision Type (check all that apply):

Amendments

New

Repeal

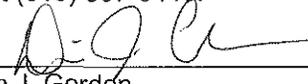
Statement of Necessity:

The Appropriations Act, Public Chapter Number 758, Section 38, Item 4.1, effective April 21, 2016, restores the fiscal year 2015-2016 budget reduction of \$1,586,600.00 to the Bureau of TennCare, which had reduced expenditures for Buprenorphine-containing products for treatment of opiate addiction for persons age 21 and older by imposing a lifetime coverage limit of 732 therapy days. This emergency rule amendment deletes the lifetime coverage limit and permits the Bureau to reinstate medically necessary treatment of opiate addiction for persons age 21 and older utilizing Buprenorphine.

T.C.A. § 4-5-208 permits an agency to adopt an emergency rule when it is required by enactment of the general assembly to implement rules within a prescribed period of time that precludes utilization of rulemaking procedures for promulgation of permanent rules.

Based upon the above information, I have made the finding that the emergency adoption of this rule is required in order to achieve immediate implementation.

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


Darin J. Gordon
Director, Bureau of TennCare
Tennessee Department of Finance and Administration

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

Chapter Number	Chapter Title
1200-13-13	TennCare Medicaid
Rule Number	Rule Title
1200-13-13-.04	Covered Services
1200-13-13-.10	Exclusions

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

Rule 1200-13-13-.04 Covered Services, Paragraph (1), Subparagraph (c), Part 9 is deleted in its entirety and is replaced with a new Part 9, which shall read as follows:

9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:
 - (i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy.
 - (ii) For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant.
 - (iii) At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

Rule 1200-13-13-.10 Exclusions, Paragraph (3), Subparagraph (a), Part 18, Subpart (vii), is amended by inserting the word "and" at the conclusion of Item (I), by deleting and replacing the punctuation at the end of Item (II) with a "." and by deleting Items (III) and (IV) in their entirety as follows:

- (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:
 - (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and
 - (II) Dosage of eight milligrams (8 mg) per day after the sixth (6th) month (183rd day) of therapy.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-13
TENNCARE MEDICAID

1200-13-13-.04 COVERED SERVICES.

- (1) Benefits covered under the managed care program
 - (c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

- 9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:
 - (i) ~~Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy. For enrollees who are pregnant while receiving this dosage, the six-month period does not begin until the enrollee is no longer pregnant. At the end of either six month period, the covered dosage amount shall not exceed eight milligrams (8 mg) per day.~~
 - (ii) ~~Therapy shall be limited to a total lifetime period of coverage not to exceed a total of 732 therapy days, which do not have to be consecutive. For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant. on day 732 of treatment, the treatment may continue until the enrollee is no longer pregnant.~~
 - (iii) ~~Effective October 1, 2015, enrollees who have exceeded 549 days of treatment will receive coverage for an additional 183 days of therapy prior to exhaustion of their lifetime coverage limits. At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.~~

1200-13-13-.10 EXCLUSIONS.

- (3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115 waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES program or outside TennCare under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

- (a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21.

18. Certain pharmacy items as follows:

- (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:
- (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and
 - (II) Dosage of eight milligrams (8mg) per day after the sixth (6th) month (183rd day) of therapy; and
 - ~~(III) Total lifetime coverage of 732 therapy days (24 months), which do not have to be consecutive, but if the enrollee is pregnant on day 732 of therapy, treatment may continue until the conclusion of pregnancy; and~~
 - ~~(IV) Effective October 1, 2015, enrollees who have exceeded 549 days (18 months) of therapy will receive coverage for an additional 183 days of therapy prior to exhaustion of their lifetime coverage limits.~~

GW10116131

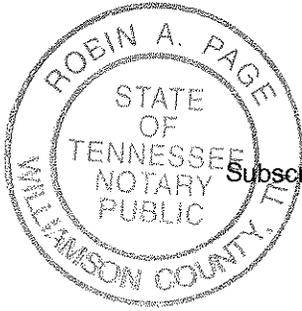
I certify that this is an accurate and complete copy of an emergency rule(s), lawfully promulgated and adopted.

Date: 5/22/2016

Signature: D.J.G.

Name of Officer: Darin J. Gordon
Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration



Subscribed and sworn to before me on: 5/22/16

Notary Public Signature: Robin A. Page

My commission expires on: 10/18/2016

All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slattery III
Herbert H. Slattery III
Attorney General and Reporter

6/23/2016
Date

Department of State Use Only

Filed with the Department of State on: 6/24/16

Effective for: 180 *days

Effective through: 12/21/16

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

RECEIVED
2016 JUN 24 AM 11:41
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PUBLICATIONS

Tre Hargett
Tre Hargett
Secretary of State

G.O.C. STAFF RULE ABSTRACT

AGENCY: Department of Finance and Administration, Bureau of TennCare

SUBJECT: TennCare Technical and Financial Eligibility

STATUTORY AUTHORITY: Tenn. Code Ann., Sections 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117

EFFECTIVE DATES: June 16, 2016, through December 13, 2016

FISCAL IMPACT: None.

STAFF RULE ABSTRACT: According to the Bureau, this emergency rule establishes a new rule chapter that sets out the requirements for applying for, obtaining, and retaining eligibility for and enrollment in the TennCare or CoverKids programs.

Impact on Local Governments

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

This Rule Chapter is not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

This is a new Rule Chapter which sets out the requirements for applying for, obtaining and retaining eligibility for and enrollment in the TennCare or CoverKids programs.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

This Rule Chapter is lawfully adopted by the Bureau of TennCare in accordance with T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons most directly affected by this Rule Chapter are applicants and enrollees of the TennCare and CoverKids programs. The governmental entity most directly affected by this Rule Chapter is the Division of Health Care Finance & Administration, Tennessee Department of Finance and Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

This Rule Chapter was approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The adoption of this Rule Chapter is not anticipated to have an effect on state and local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

John G. (Gabe) Roberts
General Counsel

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

John G. (Gabe) Roberts
General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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Nashville, TN 37243

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

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Emergency Rule Filing Form

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

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

Emergency Rule

Revision Type (check all that apply):

Amendment

New

Repeal

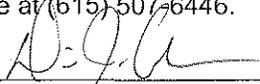
Statement of Necessity:

On December 8, 2014, the Bureau of TennCare submitted to the Centers for Medicare and Medicaid Services (CMS) requests for waivers under Section 1902(e)(14)(A) of the Social Security Act having to do with reverification of eligibility of TennCare and CoverKids enrollees. CMS approved the requests by letter dated October 21, 2015, with an acknowledgement that approval of implementation of a streamlined approach for processing eligibility renewals was necessary to protect enrollees as the State develops new systems for determining eligibility. The streamlined approach specifics of the renewal process have been agreed upon and are incorporated into this rule chapter.

T.C.A. § 4-5-208(4) permits an agency to adopt an emergency rule when it is required by an agency of the federal government and the adoption of the rule through ordinary rulemaking procedure might jeopardize the loss of federal funds.

Based upon the above information, I have made the finding that the emergency adoption of this rule is required in order to achieve immediate implementation.

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



Darin J. Gordon
Director, Bureau of TennCare
Tennessee Department of Finance and Administration

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

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

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://tn.gov/sos/pub/Rulemaking%20Guidelines_July2014.pdf)

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

Rules
of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-20
TennCare Technical and Financial Eligibility

Table of Contents

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

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

- (1) This chapter governs the processes for determining financial and categorical eligibility for the TennCare and CoverKids programs. This chapter preempts any other TennCare and CoverKids rules pertaining to eligibility determination to the extent that they are in conflict.
- (2) The Tennessee Medical Assistance Act of 1968 and Executive Order Number 23, dated October 19, 1999, designate the Tennessee Department of Finance and Administration as the Single State Agency for purposes of administering Title XIX of the Social Security Act (Medicaid).
- (3) The CoverKids Act of 2006 authorizes the Tennessee Department of Finance and Administration to establish and administer a program to provide health care coverage to uninsured children under Title XXI of the Social Security Act (State Children's Health Insurance Program – CHIP).
- (4) Titles XIX and XXI of the Social Security Act, TennCare Medicaid Section 1115 Demonstration Waiver as may be amended, extended, or renewed in the future, and 42 CFR Parts 431 and 435 require the designated State agency to provide for eligibility determinations for applicants for assistance and services provided through the programs.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

- (1) AAAD – Area Agency for Aging and Disability
- (2) ABD – Aged, Blind or Disabled
- (3) Access to Health Insurance (TennCare). See definition in Rule 1200-13-13-.01. Access to health insurance through the Federally Facilitated Marketplace shall not constitute “access to insurance” for purposes of eligibility for TennCare.
- (4) Active SSI Recipients. Persons who have been found eligible to receive SSI benefits by the SSA.
- (5) AFDC – Aid to Families with Dependent Children

- (6) Aged. An individual age 65 or older.
- (7) Aid to Families With Dependent Children (AFDC). The name of the cash assistance program for families and children prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in July 1996.
- (8) Annuities. Contracts or agreements that, in exchange for a lump sum payment or series of payments, provide for the payment of income at regular intervals, e.g., monthly, quarterly, annually, etc. Annuities establish a source of income for a future period and are often used in retirement planning.
- (9) Applicant. An individual who is seeking an eligibility determination for himself through an application submission or a transfer from another agency or insurance affordability program. For purposes of this chapter, applicant also includes an individual who is seeking an eligibility determination for himself through an application for Medicare Savings Programs (MSP).
- (10) Application. The single, streamlined form developed for use for all insurance affordability programs, as required by 42 CFR § 435.907(b), or the application form used in determining Medicaid eligibility for Long Term Services and Supports, Hospice Care, and Medicare Savings Programs.
- (11) Application File Date. See Rule 1200-13-20-.05(5).
- (12) APTC – Advanced Premium Tax Credit
- (13) APTC/CSR – Advanced Premium Tax Credit/Cost Sharing Reductions
- (14) BCCP – Breast and Cervical Cancer Prevention
- (15) Blind. An individual who is determined to be blind by the SSA.
- (16) Breast and Cervical Cancer Prevention (BCCP). The Medicaid eligibility category defined at Section 1902(aa) of the Social Security Act (42 U.S.C. § 1396a(aa)). This eligibility category covers individuals who have been found to have breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program, who are under age 65, do not otherwise have creditable coverage (including current enrollment in Medicaid), as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§ 2701(c) of the PHS Act (42 U.S.C. § 300gg(c)), are not otherwise eligible for Medicaid or receiving TennCare Standard, and who are currently undergoing treatment for breast or cervical cancer.
- (17) Bureau of TennCare (Bureau). See definition in Rule 1200-13-13-.01.
- (18) Caretaker Relative. A relative of a dependent child by blood, adoption, or marriage with whom the child lives, assumes primary responsibility for the child's care, and is one of the following:
 - (a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or
 - (b) The spouse of such caretaker relative, even after the marriage is terminated by death or divorce.
- (19) CCRC – Continuing Care Retirement Community
- (20) CHIP. The Children's Health Insurance Program established by Title XXI of the Social Security Act.
- (21) CHOICES. TennCare CHOICES in Long-Term Care, as defined in TennCare Rule 1200-13-01-.02.
- (22) CMS (Centers for Medicare & Medicaid Services). See definition in Rule 1200-13-13-.01.
- (23) Community Spouse. The legal spouse of an institutionalized individual. A community spouse may not reside

- in a medical institution or nursing facility.
- (24) Comprehensive Aggregate Cap Waiver. See definition in Tennessee's 1915(c) Home and Community Based Services Waiver.
 - (25) Completed Application. An application that meets the following criteria:
 - (a) All required fields have been completed;
 - (b) Is signed and dated by the applicant, the applicant's parent or guardian, an individual acting on behalf of the applicant, or an authorized representative;
 - (c) Includes all supporting documentation required by the Bureau to determine TennCare or CoverKids eligibility, including technical and financial requirements as set out in this chapter;
 - (d) If the application is for the TennCare Standard Medically Eligible category, it includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in this chapter.
 - (26) Continuous Eligibility. Enrollment in TennCare or CoverKids with no lapse in coverage.
 - (27) Core Medicaid Population. Individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: active SSI recipients who are receiving benefits as determined by the SSA; individuals eligible for emergency services as an undocumented or ineligible alien; individuals in a presumptive eligibility period; and children in DCS custody, including DCS children who meet the criteria for immediate eligibility and those receiving adoption assistance payments.
 - (28) CoverKids. The name given to the Children's Health Insurance Program (CHIP) in Tennessee under T.C.A. § 71-3-1101.
 - (29) CoverKids Pregnant Women/Unborn Children. Provides maternity care coverage for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage, who meet the CoverKids eligibility requirements.
 - (30) CSIMA – Community Spouse Income Maintenance Allowance
 - (31) CSRMA – Community Spouse Resource Maintenance Allowance
 - (32) DAC – Disabled Adult Child
 - (33) DCS – Department of Children's Services
 - (34) Deemed Newborn. An individual eligible in a Medicaid category authorized by Section 1902(e)(4) of the Social Security Act (42 U.S.C. § 1396a(e)(4)) and 42 CFR § 435.117.
 - (35) DIMA – Dependent Income Maintenance Allowance
 - (36) Disabled. An individual who has been determined to be disabled by the SSA.
 - (37) Disabled Adult Child (DAC). The Medicaid eligibility category defined in Section 1634(c) of the Social Security Act (42 U.S.C. § 1383c(c)).
 - (38) Effective Date. The first date of eligibility for purposes of health care services coverage and payment.
 - (39) Eligible. A person who has been determined to meet the eligibility criteria of TennCare Medicaid, TennCare Standard, or CoverKids.
 - (40) Enrollee. An individual eligible for and enrolled in the TennCare program or in any Tennessee federal

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

- (41) Enrollment. The process by which a TennCare or CoverKids eligible individual becomes enrolled in TennCare or CoverKids.
- (42) Exchange. A governmental agency or non-profit entity that meets the applicable Federal standards and makes QHPs, including TennCare and CoverKids, available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a Small Business Health Options Program (SHOP) serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by the Department of Health and Human Services (HHS).
- (43) Extended Medicaid. Medicaid eligibility authorized for enrollees who lose Child MAGI, Pregnancy MAGI, or Caretaker Relative MAGI eligibility due to increased receipt of spousal support, whose household income prior to losing eligibility was at or below the current Caretaker Relative MAGI income standard for 3 of the 6 months preceding the month of the increase in income.
- (44) Families First (FF). Tennessee's Temporary Assistance for Needy Families (TANF) program was created by the PRWORA in 1996. TANF became effective in July 1996 and replaced what was then commonly known as the AFDC program.
- (45) Federal Data Services Hub. An electronic service established by the HHS to facilitate sharing of data and other information between federal agencies, State agencies, and other entities involved in administering Insurance Affordability Programs.
- (46) Federal Financial Participation (FFP). See definition in Rule 1200-13-13-.01.
- (47) Federal Poverty Level (FPL). The poverty level established annually by HHS.
- (48) Federally Facilitated Marketplace (FFM). See "Exchange."
- (49) FEMA – Federal Emergency Management Agency
- (50) FF – Families First
- (51) FFM – Federally Facilitated Marketplace
- (52) FFP – Federal Financial Participation
- (53) Financially Responsible Relatives (FRR). Principle of financial responsibility between spouses and parents to their children which is used in determining household composition, income counting and resource counting for certain Medicaid categories.
- (54) Former Foster Care Children Under 26. The Medicaid eligibility category defined at Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(A)(i)(IX)).
- (55) FPL – Federal Poverty Level
- (56) FRR – Financially Responsible Relatives
- (57) Full-Time Student. A student is defined as a child under age 21, unless otherwise specified in this chapter, attending primary or secondary school, college, university, or a course of vocational or technical training.

- (a) A child retains his or her student status during official school vacations and breaks if the requirement prior to the vacation or break was met, and the student plans to return.
 - (b) A child who is receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher meets student requirements.
 - (c) An elementary school is defined as a State-approved educational institution comprised of grade kindergarten through eighth grade.
 - (d) Participation in apprenticeships, correspondence courses, other courses of home study and rehabilitation programs other than academic, institutional, vocational or technical training do not qualify a child as a student.
 - (e) A full-time student for college or university is an individual who is enrolled in at least 12 credit or semester hours per semester. A part-time student is an individual who is enrolled in at least 6 but less than 12 credit or semester hours per semester. (T.C.A. §§ 49-4-902(18) and (29)).
- (58) Group Health Insurance. An employee benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50-or-more participants criteria do not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.
- (59) HCBS – Home and Community Based Services
- (60) HCFA – Health Care Finance and Administration
- (61) Health Care Finance and Administration (HCFA). The State agency that oversees most of the health care related divisions within the Tennessee Department of Finance and Administration, including the Bureau of TennCare, the Office of eHealth, the Cover Tennessee Programs and the Strategic Planning and Innovation Group.
- (62) Health Insurance (for CoverKids).
- (a) Health insurance including, but not limited to, basic medical coverage (hospitalization plans), major medical insurance, comprehensive medical insurance, short-term medical policies, mini-medical plans, and high-deductible plans with health savings accounts. For purposes of eligibility, other coverage includes Medicare, TennCare, TRICARE, employer-sponsored coverage.
 - (b) Health insurance shall not include the following:
 1. CoverTN;
 2. AccessTN;
 3. Catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of \$3,000 (or the maximum allowed deductible for a health savings account plan);
 4. Dental-only plans;
 5. Vision-only plans;
 6. Benefits provided by the U.S. Department of Veterans Affairs or the Indian Health Service.

7. Coverage under the State of Tennessee's Children's Special Services program; or
 8. Medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (Pub. L. No. 99-272, 29 U.S.C. §§ 1161, et seq.) and which the individual declined, or to T.C.A. §§ 56-7-2312, et seq., and which the individual declined.
- (c) Consistent with 42 U.S.C. § 1397jj(b)(2)(B) and 42 CFR. §§ 457.301 and 457.310(c)(1)(ii), health insurance shall not include State-administered or other medical coverage offered by means of a family member's employment with a local education agency (LEA) if the LEA does not make more than a nominal contribution (as defined at 42 CFR § 457.310(c)(1)(ii)) to the premium for the dependent, who is applying (or re-applying) for coverage through CoverKids.
- (63) Health Insurance (for TennCare).
- (a) Health insurance, for purposes of determining eligibility under these rules, shall mean:
1. Any hospital or medical expense-incurred policy;
 2. Medicare;
 3. TRICARE;
 4. COBRA;
 5. Medicaid;
 6. State health high-risk pool;
 7. Nonprofit health care service plan contract;
 8. Health maintenance organization subscriber contracts;
 9. Group Health Insurance;
 10. Coverage available to an individual through membership in a professional organization or a school;
 11. Coverage under a policy covering one person or all members of a family under a single policy where the contract exists solely between the individual and the insurance company;
 12. Any of the above types of policies for which:
 - (i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;
 - (ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;
 - (iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition.
 13. Any of the types of policies listed in (12) will be considered Health Insurance even if one or more of the following circumstances exists:
 - (i) The policy contains fewer benefits than TennCare;

- (ii) The policy costs more than TennCare; or
 - (iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.
- (b) Health insurance, for purposes of determining eligibility under these rules, shall not mean:
1. Short term coverage;
 2. Accident coverage;
 3. Fixed indemnity insurance;
 4. Long-term care insurance;
 5. Disability income contracts;
 6. Limited benefits policies as defined elsewhere in these rules;
 7. Credit insurance;
 8. School-sponsored sports-related injury coverage;
 9. Coverage issued as a supplement to liability insurance;
 10. Automobile medical insurance;
 11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
 12. A medical care program of the Indian Health Services (IHS) or a tribal organization;
 13. Benefits received through the U.S. Department of Veterans Affairs; or
 14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White CARE Act.
- (64) Health Insurance Marketplace a.k.a. "Marketplace", "Exchange" or "Federally Facilitated Marketplace". See "Exchange."
- (65) Home and Community Based Services (HCBS). See Rule 1200-13-01-.02.
- (66) Household Size. The number of persons counted as members of an individual's household for purposes of determining eligibility for TennCare or CoverKids.
- (67) ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities.
- (68) Immediate Eligibility (for DCS children only). An arrangement whereby children in the custody of the State who are presumed to be TennCare-eligible may gain TennCare eligibility while their applications are being processed.
- (69) Inactive SSI Enrollee. Individuals whose SSI cash benefits have been terminated by SSA and who remain eligible for TennCare until they have been reviewed for coverage in other eligibility categories. Inactive SSI enrollees are not eligible for CHOICES.
- (70) Incarcerated. The state of being confined in a local, State, or federal prison, jail, youth development center,

or other penal or correctional facility, including the state of being on furlough from such facility.

- (71) Individual Health Insurance. Health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.
- (72) Infants and Children Under Age 19. The Medicaid eligibility categories defined at Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX); and 1396u-1(b) and (d)).
- (73) Insurance Affordability Program. A program that is one of the following:
 - (a) TennCare.
 - (b) CoverKids.
 - (c) APTC/CSR for participation in a QHP available through the FFM.
- (74) Institutional Spouse. An institutionalized individual who is the legal spouse of a community spouse.
- (75) Institutionalized Individual(s). The Medicaid eligibility category defined at Section 1902(a)(10)(A)(ii)(V) of the Social Security Act. (42 U.S.C. § 1396a(a)(10)(A)(ii)(V)).
- (76) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An institution described at 42 CFR Part 483, Subpart I.
- (77) IRA – Individual Retirement Account
- (78) ITEM D. The term used in Tennessee to refer to the methodology for deducting incurred expenses for necessary medical or remedial care for institutionalized persons in the post-eligibility phase of income defined at 42 CFR §§ 435.725(c)(4), 435.726(c)(4) and 435.832.
- (79) Joint Custody. Legal custody of a child held simultaneously by two (2) or more caretaker relatives. The caretaker relatives must exercise care and control of the child.
- (80) Limited Benefits Policy. A policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).
- (81) Long-Term Care. See “Long-Term Services and Supports” (LTSS).
- (82) Long-Term Services and Supports (LTSS) Program. See definition in Rule 1200-13-01-.02.
- (83) LTSS – Long-Term Services and Supports
- (84) MAGI – Modified Adjusted Gross Income
- (85) Marketplace. See “Exchange.”
- (86) Medicaid. See definition in Rule 1200-13-13-.01.
- (87) Medicaid Income Cap (MIC). 300% of the SSI Federal Benefit Rate.
- (88) Medicaid “Rollover” Enrollee. A TennCare Medicaid enrollee under the age of 19 who no longer meets eligibility requirements for Medicaid and who is afforded an opportunity to enroll in TennCare Standard in

accordance with the provisions of these rules.

- (89) Medically Needy. The Medicaid eligibility category described at Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(C)).
- (90) Medically Needy Income Standard (MNIS). See definition at 42 CFR § 435.811.
- (91) Medicare. The program administered through the SSA pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to some individuals that have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).
- (92) Medicare Buy-In. The process by which TennCare “buys” Medicare beneficiaries into the Medicare program. The Medicare buy-in consists of paying for some or all of a beneficiary’s Medicare premiums, deductibles, and coinsurance.
- (93) Medicare Savings Program (MSP). One of the programs under which low-income Medicare beneficiaries can get assistance from Medicaid for paying for some or all of their Medicare premiums, deductibles, and coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, the Qualifying Individual (QI1) program and the Qualified Disabled and Working Individual (QDWI) program.
- (94) Member. See “Enrollee.”
- (95) MIC – Medicaid Income Cap
- (96) Miller Trust. See “Qualified Income Trust.”
- (97) MNIS – Medically Needy Income Standard
- (98) Modified Adjusted Gross Income (MAGI). See definition at 42 CFR § 435.603(e).
- (99) MSP – Medicare Savings Program
- (100) Newborn Presumptive. The Medicaid eligibility category described at 42 CFR § 435.1102.
- (101) Nursing Facility (NF). See definition in Rule 1200-13-01-.02.
- (102) PACE – Program of All-Inclusive Care for the Elderly
- (103) PACE Carryover Group. See definition in Rule 1200-13-01-.02.
- (104) PASS – Plan to Achieve Self Support
- (105) Patient Liability. See definition in Rule 1200-13-01-.02.
- (106) Payment for Emergency Medical Services. Eligibility authorized by Section 1903(v) of the Social Security Act (42 U.S.C. § 1396b(v)).
- (107) Personal Needs Allowance. See definition in Rule 1200-13-01-.02.
- (108) Pickle Passalong. The eligibility category defined at 42 CFR § 435.135.
- (109) Pregnant Women. For purposes of the Medicaid program, the Medicaid eligibility category defined at Sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Social Security Act, (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX)); and 1396u-1(b) and (d)); and 42 CFR 435.116.

- (110) Presumptive Eligibility for Individuals with Breast or Cervical Cancer. Individuals presumed to be eligible for coverage under the Medicaid category authorized by Section 1902(aa) of the Social Security Act (42 U.S.C. § 1396a(aa)) based on a determination by the Tennessee Department of Health or other qualified entity.
- (111) Presumptive Eligibility for Pregnant Women. Women presumed to be eligible for coverage in the category defined at Sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), (IX); and 1931(b) and (d) of the Social Security Act, (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX); and 1396u-1(b) and (d)); and in 42 CFR 435.1103 by the Tennessee Department of Health or other qualified entity.
- (112) Program of All-Inclusive Care for the Elderly (PACE). See definition in Rule 1200-13-01-.02.
- (113) QDWI – Qualified Disabled and Working Individual
- (114) QHP – Qualified Health Plan
- (115) QI1 – Qualifying Individual
- (116) QIT – Qualified Income Trust
- (117) QMB – Qualified Medicare Beneficiary
- (118) Qualified Disabled and Working Individual (QDWI). An individual who is under age sixty-five (65), has lost free Medicare Part A coverage due to substantial gainful activity, has a disabling impairment, has the option to purchase Medicare Part A for an indefinite period of time, and for whom Medicaid pays the Medicare Part A premium, if income is not more than two hundred percent (200%) of the federal poverty level and resources are not more than twice the SSI limit and is not otherwise eligible for Medicaid. Eligibility is authorized by Sections 1905(p)(3)(A)(i);, 1905(s); and 1902(a)(10)(E)(ii) of the Social Security Act, (42 U.S.C. §§ 1396d(p)(3)(A)(i) and (s); and 1396a(a)(10)(E)(ii)).
- (119) Qualified Health Plan (QHP). See definition at 42 USC 18021.
- (120) Qualified Income Trust (QIT). The trust defined at 42 U.S.C. § 1396p(d)(4)(B).
- (121) Qualified Long-Term Care Insurance Policy. A long-term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to Rule 0780-01-61 as:
- (a) A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or
 - (b) A policy that has been issued in another Partnership State and which is covered under a reciprocal agreement between such other State and the State of Tennessee.
- (122) Qualified Medicare Beneficiary (QMB). An individual who is entitled to and receives Medicare Part A and for whom Medicaid pays the Medicare Part A and Part B premium, coinsurance, and deductible for Medicare-covered services and whose income is not more than one hundred percent (100%) of the federal poverty level. Eligibility is authorized by Sections 1905(p) and 1902(a)(10)(E)(i) of the Social Security Act, (42 U.S.C. §§ 1396d(p) and 1396a(a)(10)(E)(i)).
- (123) Qualifying Individual 1 (QI1). An individual who is entitled to and receives Medicare Part A, for whom Medicaid pays Medicare Part B premiums on a first-come, first-served basis, and who has income at least one hundred and twenty percent (120%) of the federal poverty level but not more than one hundred and thirty-five percent (135%) of the federal poverty level. Individuals are not enrolled in TennCare Medicaid or TennCare Standard. Eligibility is authorized by Section 1902(a)(10)(E)(iv) of the Social Security Act, (42 U.S.C. § 1396a(a)(10)(E)(iv)) and 42 U.S.C. § 1396u-3.
- (124) Qualifying Medical Condition. A medical condition which is included among a list of conditions established

by the Bureau and which will render a qualified uninsured applicant medically eligible.

- (125) Redetermination. The process by which TennCare evaluates the ongoing eligibility status of TennCare Medicaid enrollees who are considered a part of the Core Medicaid Population, as well as TennCare Standard and CoverKids enrollees. This is a periodic process that is conducted at specified intervals. The process is conducted in accordance with TennCare's, or its designee's, policies and procedures. This is also referred to as "Renewal."
- (126) Renewal. See "Redetermination."
- (127) Responsible Party(ies). The following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, and guardians; as defined at T.C.A. § 71-5-103(12).
- (128) Single State Agency (CoverKids and TennCare). The Department of Finance and Administration.
- (129) SLMB – Specified Low Income Medicare Beneficiary.
- (130) Specified Low-Income Medicare Beneficiary (SLMB). A person who is eligible for Medicare Part A and for whom Medicaid pays Medicare Part B premiums, if income is at least one hundred percent (100%) of the federal poverty level but not more than one hundred twenty percent (120%) of the federal poverty level. Eligibility is authorized by Sections 1905(p)(3)(A)(ii) and 1902(a)(10)(E)(iii) of the Social Security Act, (42 U.S.C. §§ 1396d(p)(3)(A)(ii) and 1396a(a)(10)(E)(iii)).
- (131) Spenddown. The process by which excess income is utilized for recognized medical expenses and which, when depleted, results in a determination of eligibility if all other eligibility factors are met.
- (132) SSA – Social Security Administration
- (133) SSI – Supplemental Security Income
- (134) SSI – Related Groups. Individuals who have been found eligible in one of the following categories:
 - (a) Disabled Adult Children (DAC).
 - (b) Pickle Passalong.
 - (c) Widow/Widowers.
- (135) Standard Child Medically Eligible. An uninsured child under age nineteen (19) who is losing eligibility for Medicaid or currently enrolled in TennCare Standard, whose household income exceeds two hundred and eleven percent (211%) of the federal poverty level, who does not have access to health insurance, and who has been determined medically eligible in accordance with these rules.
- (136) Standard Child Uninsured. The TennCare Demonstration category defined as including persons in the following groups:
 - (a) Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, or are currently enrolled in TennCare Standard, who have household incomes at or below two hundred and eleven percent (211%) of the federal poverty level, and who do not have access to health insurance; or
 - (b) Uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below two hundred percent (200%) of the federal poverty level, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. At such time as a person loses eligibility in this category, he will not be able to re-enroll in it.

- (137) Supplemental Security Income (SSI). A federal income supplement program funded by general tax revenues and is designed to help aged, blind and disabled individuals who have little or no income. Applications for SSI benefits are filed at the Social Security office. Individuals who are eligible for SSI are automatically entitled to Medicaid (42 U.S.C. §§ 1382, et seq.).
- (138) TANF – Temporary Assistance for Needy Families
- (139) Temporary Assistance for Needy Families (TANF). A program created by the PRWORA in 1996. TANF became effective in July 1996 and replaced what was then commonly known as the AFDC program. The name given to Tennessee's TANF program is Families First.
- (140) TennCare. The program administered by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee.
- (141) TennCare CHOICES in Long-Term Services and Supports. The program described in Rule 1200-13-01-.05. CHOICES is a benefit package available to TennCare enrollees who are eligible in the Institutional eligibility category or who are active SSI enrollees and who meet the requirements of the program set out in chapter 1200-13-01.
- (142) TennCare Medicaid. That part of the TennCare program which covers persons eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following persons are eligible for TennCare Medicaid:
- (a) Tennessee residents determined to be eligible for Medicaid in accordance with this chapter.
 - (b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.
 - (c) A Tennessee resident who is an uninsured individual, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, and has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.
 - (d) Tennessee residents determined eligible for SSI benefits by the SSA are automatically enrolled in TennCare Medicaid.
- (143) TennCare Standard. That part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in this chapter.
- (144) Tennessee Health Connection (TNHC). Working title of the entity contracted with TennCare to provide service center functionality, including a call center and document intake.
- (145) Termination. See definition in Rule 1200-13-13-.01. Also means the discontinuance of an enrollee's coverage under the CoverKids program.
- (146) Title IV-E. The section of the Social Security Act under which grants are made to States for implementation of foster care and adoption assistance programs. Eligibility is authorized by Section 1902(a)(10)(A)(i)(I) of the Social Security Act, 42 CFR 435.115, and 42 CFR 435.145.
- (147) TNHC – Tennessee Health Connection
- (148) Transitional Medicaid. Medicaid authorized for enrollees who lose Child MAGI, Pregnancy MAGI, or Caretaker Relative MAGI eligibility due to increased earnings and whose household income prior to losing eligibility was at or below the current Caretaker Relative MAGI income standard for 3 of the 6 months immediately preceding the month of the increase in income.

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

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

(151) WIA – Workforce Investment Act

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

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

(1) Agencies' Roles and Responsibilities.

- (a) The Bureau of TennCare (Bureau) is responsible for determining eligibility for both TennCare and CoverKids and for conducting appeals of eligibility-related decisions, unless otherwise agreed to by the Single State Agency and CMS. The Bureau is also responsible for coordinating the eligibility process for TennCare and CoverKids with the eligibility process for APTC/CSR in the FFM, in accordance with 42 CFR §§ 435.1200 and 1205, unless otherwise agreed to by the Single State Agency and CMS.
- (b) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for some TennCare Medicaid and TennCare Standard applicants who have open SNAP cases, as well as to redetermine, at regular intervals, whether eligibility should be continued for some enrollees. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.
- (c) With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.
- (d) The Tennessee Department of Children's Services is responsible for determining eligibility for Medicaid foster care and adoption assistance categories.
- (e) The Tennessee Department of Health (DOH) is responsible for conducting presumptive eligibility determinations for pregnant women and individuals in the BCCP category.
- (f) The SSA is responsible for determining eligibility for receipt of benefits from the SSI program. Individuals receiving SSI payments in Tennessee determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid.
- (g) The FFM is responsible for making TennCare Medicaid and CoverKids eligibility determinations for categories using MAGI income methodologies based on an agreement between the State and the FFM. The FFM is also responsible for assessing applicants who may be eligible for other Medicaid eligibility categories and transmitting those applicants to the State for full review.
- (h) The Bureau is responsible for notifying applicants of recovery for LTSS expenditures. Section 1917 of the Social Security Act (42 U.S.C. § 1396p), 42 CFR §§ 433.36 and 435.700, et seq., and T.C.A. § 71-5-116.

(2) Enrollee Roles and Responsibilities.

- (a) Each TennCare enrollee and each CoverKids enrollee is responsible for reporting to HCFA, any material change in the information affecting eligibility given by the applicant/enrollee to the Bureau of

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

- (b) All verifications requested must be furnished within 10 days of the notice requesting additional information unless otherwise specified by federal law.
- (c) Each TennCare enrollee and each CoverKids enrollee is responsible for reporting to his provider that he is a TennCare or CoverKids enrollee.
- (d) By accepting medical assistance through the TennCare program, every enrollee is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Persons applying as Caretaker Relatives under Medicaid (see Rule 1200-13-20-.07) must cooperate in establishing the paternity of dependent children and obtaining medical support. Failure to cooperate in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating TennCare eligibility.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

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

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

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

1. The absence is for a specific purpose such as a temporary work assignment, visit, hospitalization, participation in an educational or rehabilitation program not available in Tennessee; or
2. The absence is for a child receiving specialized treatment out of State; and
3. The individual indicates his intent to return to Tennessee once the purpose for his absence is accomplished.

(b) Students.

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

(2) Citizenship. Persons enrolled in TennCare or CoverKids must meet the requirements for citizenship or

qualified non-citizen status established in 42 CFR § 435.406.

- (a) Qualified aliens who entered the United States on or after August 22, 1996, are barred from receiving TennCare Medicaid or CoverKids benefits for five years from the date of entering the U.S. before potential eligibility for TennCare or CoverKids unless they meet the exceptions to the five (5) year bar as outlined in 8 U.S.C. § 1613(b).
 - (b) For CoverKids, unborn children are presumed to be U.S. citizens, regardless of the citizenship or immigration status of the mother.
- (3) Social Security Number (SSN).
- (a) Persons enrolled in TennCare or CoverKids must meet the requirements of 42 CFR § 435.910.
 - (b) Unborn children enrolled in CoverKids Pregnant Women/Unborn Children are not required to have an SSN.
 - (c) SSNs are not required for members of households who are not applying for TennCare or CoverKids coverage.
- (4) Incarceration. Persons who are incarcerated are eligible for TennCare in a suspended status pursuant to T.C.A. § 71-5-106(r), as long as all eligibility criteria are met. Persons in a suspended status will be eligible for TennCare payments for medical institution stays longer than 24 hours only. All other medical payments while in the suspended status are not subject to TennCare reimbursement. The suspended status will be removed once the State receives notice that the enrollee is no longer incarcerated. See also 42 CFR § 435.1010.
- (5) Residents of an Institution for Mental Disease (IMD). Persons who are residents of an IMD are not eligible for FFP, except for those who are age 65 or older and confined to an approved ward, or those who are under age 22 and receiving inpatient psychiatric services. Confinement in an IMD does satisfy and establish institutional status for individuals under 65 and those confined to unapproved wards who are subsequently admitted to a medical institution. See Section 1905 of the Social Security Act (42 U.S.C. § 1396d).

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

- (1) Right to apply.
- (a) Any person wishing to do so shall have the opportunity to apply for TennCare Medicaid or CoverKids without delay.
 - (b) Information about the TennCare or CoverKids program administered by HCFA shall be provided to any person requesting it pursuant to 42 CFR § 435.905.
 - (c) Applications may be filed by the applicant, his authorized representative or someone acting responsibly for him. See 42 CFR § 435.923.
 - (d) Proof of eligibility is not required of a person prior to filing an application.
 - (e) The right to file an application shall not be denied to any person even if it is apparent that eligibility for TennCare or CoverKids does not exist.
- (2) Rights and responsibilities.
- (a) By applying for TennCare or CoverKids, an applicant grants permission and authorizes release of

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

1. The United States Internal Revenue Service (IRS);
 2. State income tax records for Tennessee or any other State where income is earned;
 3. The Tennessee Department of Labor and Workforce Development, and other Employment Security offices within any State where the applicant may have received wages or been employed;
 4. Credit bureaus;
 5. Insurance companies; or,
 6. Any other governmental agency or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare or CoverKids Program. The Federal Data Services Hub, or "electronic service" referred to in 42 CFR § 435.949, is an example of such an information source.
- (b) It is a felony offense, pursuant to T.C.A. § 71-5-2601, to apply for TennCare coverage under false means or to help anyone obtain TennCare under false means.
- (c) By applying for TennCare Medicaid, an applicant agrees to provide information to the Bureau, or its designee, about any third party coverage in which the applicant is enrolled.
- (3) Submitting an application.
- (a) TennCare will accept applications in accordance with 42 CFR § 435.907 and, for CoverKids applicants, 42 CFR § 457.330, or as otherwise agreed to by the Single State Agency and CMS.
- (b) An application can be filed by one of the following individuals, as applicable:
1. Adult applicants or an adult who is in the applicant's household as defined in 42 CFR § 435.603(f);
 2. An adult who is in the applicant's family, as defined in the Internal Revenue Code § 36B(d)(1);
 3. Applicants who are over age 14 but under age 18 who are emancipated or are considered sufficiently mature to make their own health care decisions;
 4. A parent who has primary custody of a minor child;
 5. Either parent of a minor child when custody is equally divided between legal parents;
 6. The legal guardian or conservator;
 7. An authorized representative, as defined in 42 CFR § 435.923; or
 8. If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.
- (c) Applications received from Tennessee residents living out of State.
1. Applications filed for Tennessee residents who are temporarily out of State may be accepted.

2. The application of someone who is hospitalized in another State and planning to return to Tennessee when discharged may be processed in the usual manner.
- (d) Out of State applicants.
1. Applications received from persons residing in another State and not intending to reside in Tennessee will be denied.
 2. Persons who are in Tennessee for a temporary purpose, such as a visit, who intend to return to their home out of State are not eligible for TennCare or CoverKids.
 3. Applicants must always be given the right to submit an application if they wish to do so and receive a decision on their application.
- (4) Assistance with submitting an application. HCFA is required to provide assistance to any individual seeking help with the application or redetermination process in person by Certified Application Counselors (CACs), over the phone, and online in a manner that is accessible to individuals with disabilities and those who have limited English proficiency. Assistance includes, but is not limited to, the following:
- (a) Help with form completion;
 - (b) Help securing a representative, if needed, and/or allowing someone of the applicant's choice to assist with the application and renewal process; and
 - (c) Help in obtaining necessary information from third parties.
- (5) Applications may be filed in any of the following ways:
- (a) By mail.
 1. LTSS and MSP: Paper LTSS/MSP applications must be submitted to TNHC. The Application File Date for LTSS/MSP applications mailed to TNHC will be the date the application is received at TNHC.
 2. All categories of TennCare and CoverKids except MSPs:
 - (i) Mail paper applications to the FFM. The Application File Date will be the date provided by the FFM.
 - (ii) Mail an application to TNHC. If an FFM application is mailed to TNHC, the State will forward the application to the FFM to be processed. The Application File Date will be the date provided by the FFM, or as otherwise agreed to by the Single State Agency and CMS.
 - (b) By phone.
 1. LTSS and MSP: Call TNHC or the local AAAD (or MCO if current TennCare enrollee). TNHC will provide a paper application that must be submitted by mail or fax. The Application File Date for LTSS/MSP applications will be the date the application is received at TNHC.
 2. All other categories of TennCare and CoverKids except MSPs: Call the FFM. The Application File Date will be the date provided by the FFM.
 3. Newborn applicants may call TNHC to either be added as a Deemed Newborn or apply for Newborn Presumptive coverage. The Application File Date for a Newborn Presumptive will be the date of determination by the qualified entity.

- (c) By fax.
 - 1. LTSS and MSP or EMS (Emergency Medical Services) applicants: Fax an application to TNHC. The Application File Date for LTSS/MSP/EMS applications faxed to TNHC will be the date the application is received at TNHC.
 - 2. All other categories of TennCare and CoverKids: Fax application to TNHC. If an FFM application is faxed to TNHC, the State will forward the application to the FFM to be processed. The Application File Date will be the date provided by the FFM, or as otherwise agreed to by the Single State Agency and CMS.
- (d) By online submission of the application through the FFM. The Application File Date will be the date provided to the State by the FFM.
- (e) In person at any DHS county office.
 - 1. LTSS and MSP: Submit a paper LTSS/MSP application at the local DHS office. The Application File Date for LTSS/MSP applications submitted to DHS will be the date of receipt at DHS.
 - 2. All categories of TennCare and CoverKids other than MSPs: Complete an online application by using a kiosk at a DHS office or by telephone. Applications filed with the FFM, using the FFM Web site, call center or paper application, are processed by the FFM. Once processed, the federal government transmits the applicant's information to HCFA through an electronic file.
- (6) Processing time. Eligibility will be timely determined in accordance with 42 CFR § 435.912, or as otherwise agreed to by the Single State Agency and CMS.
- (7) Disposition.
 - (a) Eligibility is determined based on information contained on the completed application form as well as information secured during the application process.
 - (b) All applications will be subject to one (1) of the following actions:
 - 1. Approval. When all eligibility factors are met, the application is approved.
 - 2. Denial. When one or more eligibility factor(s) is not met, the application is denied.
 - (i) Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.
 - (ii) Applicants who do not respond to requests for verifications by the State in a timely manner will be denied for failure to respond to such requests.
 - (iii) Applicants who do not provide sufficient information in response to requests for verifications by the State will be denied.
 - (c) Withdrawal. When an applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

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

- (a) All applicants for TennCare or CoverKids will have their income calculated for eligibility purposes in accordance with the MAGI-based requirements at 42 CFR § 435.603. The only exceptions are the Medicaid applicants at 42 CFR §§ 435.603(j)(1)-(6).
- (b) In accordance with 42 CFR § 435.603(g)(1), there is no resource or asset test for individuals whose income eligibility is required to be determined using MAGI income requirements.
- (c) There is no resource or asset test for pregnant women or children enrolled in CoverKids.
- (d) In accordance with 42 CFR § 435.603(g)(2), there are no income or expense disregards for individuals whose eligibility is determined in accordance with MAGI requirements, with the exception of those described at 42 CFR §§ 435.603(d)(1) and (4).
- (e) Household composition, for financial eligibility determination purposes, for TennCare Medicaid (Child, Pregnant Women and Caretaker Relative categories), TennCare Standard Children Uninsured, TennCare Standard Medically Eligible, and the CoverKids categories will be determined using the MAGI methodology in accordance with 42 CFR § 435.603(f). Household composition for all other categories will be determined in accordance with this chapter. MAGI household composition methodology is based on federal tax rules and the principles of tax dependency, however the MAGI rules apply to both applicants who expect to file taxes or be claimed as tax dependents, and to those applicants who do not file taxes or are not claimed as tax dependents. Each applicant has his own household size constructed under MAGI rules, and it is permissible for applicants who live in the same household to have different household sizes.

1. Tax Filers.

- (i) For applicants who expect to file taxes, the household includes the tax filer and any dependents the tax filer expects to claim.
- (ii) For applicants claimed as tax dependents, the household is the same as the tax filer claiming the tax dependent. Tax dependents may include individuals not otherwise eligible for TennCare Medicaid or CoverKids, and who are not applying for benefits. If a non-custodial parent claims a child as a dependent, the dependent child will be included in the non-custodial parent's household size.
- (iii) For married couples who live together, each spouse will always be included in the other spouse's household, regardless of the couple's tax filing status.
- (iv) There are three exceptions to the tax filer rule for applicants claimed as tax dependents. An applicant who meets any of the following is subject to the non-filer household composition rules:
 - (I) The tax filer is someone other than the applicant's spouse, or natural, adopted or step parent; or
 - (II) The applicant is under age 19, or 21 if a full-time student, and is claimed as a tax dependent by one parent, but his or her parents live together and do not file a joint tax return; or
 - (III) The applicant is under age 19, or 21 if a full-time student, and expects to be claimed as a tax dependent by a non-custodial parent.

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

- (i) The applicant's spouse;

- (ii) The applicant's natural, adopted and step children under age 19, or 21 if a full-time student;
 - (iii) For applicants under age 19, or 21 if a full-time student, the applicant's natural, adopted or step parent; and
 - (iv) For applicants under age 19, or 21 if a full-time student, the applicant's natural, adoptive and step siblings who are under age 19, or 21 if a full-time student.
- (f) The household size for a pregnant woman includes the number of children she is expected to deliver (the unborn child(ren)). The household size for other applicants in a pregnant woman's household does not include the unborn child(ren).
- (2) AFDC-Related Financial Determinations.
- (a) Coverage groups whose financial eligibility is determined in accordance with AFDC-based methodologies are:
 1. Medically Needy Children; and
 2. Qualified Medically Needy Pregnant Women.
 - (b) Income Determinations. Income for individuals described in this paragraph is calculated according to the AFDC cash assistance program's income definitions and policies (Tenn. Comp. R. & Regs. 1240-01-04-.12 and .14 - .19, and 45 CFR § 233.20). Unless otherwise specified below, these individuals are subject to the following income requirements:
 1. Adoption Subsidies – Countable to the child if intended for general living expenses. Excluded if for reimbursement of child care while the adult responsible for the child is at work or seeking employment, for medical expenses, or from State adoption assistance programs or Title IV-E funds for special needs children.
 2. Alimony Received – Countable.
 3. Annuity Payments – If the underlying annuity is an excluded resource, the periodic payments are countable unearned income. If the underlying annuity is a countable resource, payments are excluded.
 4. Assistance Payment from another State – Countable.
 5. Bonuses – Countable.
 6. Cancelled Debts – Excluded.
 7. Capital Gains – Countable.
 8. Cash Support – Countable, unless excluded as infrequent or irregular income.
 9. Census Payments – Excluded.
 10. Child Support Payments – Countable, both current payments and arrears.
 11. Child/Spousal Support Transferred to IV-D Agency – Payments transferred by the household to DCS as assigned support are excluded.
 12. Commissions – Countable.

13. CSIMA – Countable as unearned income only when the institutionalized individual is not in the community spouse’s household.
14. Contractual Payments – Countable.
15. Death Benefits – Countable income to an individual if the total amount exceeds the expense of the deceased person’s last illness and burial paid by the individual to whom the death benefit is issued.
16. Deferred Wages – Countable when the income would have normally been received if the wages are deferred at the employee’s request. Countable when received if the wages are deferred by the employer.
17. DIMA – Countable as unearned income only when the institutionalized individual is not in the dependent’s household.
18. Differential Payments – Countable.
19. Domestic Commercial Transportation Tickets – Excluded as long as tickets are not converted to cash.
20. Domestic Volunteer Service Act Payments – Excluded as income if payments are made for supporting services or reimbursements for out-of-pocket expenses.
21. Dwelling-related Assistance – Excluded if housing assistance is provided by HUD or FMHA.
22. Earned Income Tax Credits – Excluded.
23. In-Kind Income: Wages, Food, Shelter or other – Countable.
24. Earned In-Kind Food or Shelter – Countable.
25. Earned In-Kind Not Food or Shelter – Countable.
26. Earned In-Kind Wages – Countable.
27. Education Income that is Not Work Study – Includes: Pell Grant; SEOG Grant; National Direct Student Loan; Guaranteed Student Loan; State Student Initiative and any financial aid:
 - (i) Excluded - if paid directly to the school and unavailable to the student.
 - (ii) Countable - as unearned income: Any portion of the grant, scholarship or fellowship that is not used to pay tuition, fees, or other necessary education expenses.
28. FF/TANF Payments – Excluded.
29. Farmer Income – Countable.
30. Farmer/Fishing Income – Countable.
31. Gambling Prizes and Awards – Countable.
32. Gifts – Cash gifts are countable unless excluded as infrequent or irregular income. In-Kind gifts are countable, and the value is equal to the current market value.
33. Income Produced from Resources – Countable.

34. Inheritance Cash – Countable.
35. Interest Bearing Resources – Interest earned on a resource, dividends, royalties and other direct money payments is countable.
36. Interest on Burial Funds and Spaces – Excluded.
37. Irregular or Infrequent Income – Up to \$30 of unearned or earned income received infrequently or irregularly per quarter is excluded.
38. Jury Duty Pay – Countable unless the income is turned over to an applicant's employer.
39. Low Income Home Energy Assistance Payments (LIHEAP) – Excluded.
40. Military Allotments – The Family Subsistence Supplemental Allowance (FSSA) and the Military Basic Allowance for Housing (BAH) are countable as unearned income.
41. Payments from FEMA – FEMA payments issued as a result of presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by States, local governments and disaster assistance organizations are also excluded. FEMA payments which are made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable.
42. Pensions – Countable.
43. PASS Payments – Excluded.
44. Protective Payee Payments – Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his or her own use is countable income to the protective payee. Even if the protective payee retains a fee for his or her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.
45. Railroad Retirement Payments – Countable.
46. Rehabilitation Payments – Net rehabilitation payments are countable as unearned income. Deduct allowable expenses from the gross rehabilitation payment.
47. Reimbursements – Reimbursement of expenses an employee incurs in the performance of his or her duties for items other than normal living expenses are excluded.
48. Rental or Lease Income – Countable as earned income when the individual is actively engaged in producing such income, or bears some responsibility in earning the income. Countable as unearned income when the individual is not actively engaged in producing the income, or bears no responsibility in earning the income. Count the amount of income remaining after expenses related to maintaining the property are applied.
49. Royalties and Honoraria – Countable.
50. Self Employment – Net earnings are countable.
51. Settlements and Restitutions – The following settlements and restitution payments are excluded as unearned income:

- (i) Filipino Veterans Compensation Fund Payments. Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;
 - (ii) Agent Orange Settlement Payments. Excluded as unearned income but counted when determining patient liability for institutionalized individuals;
 - (iii) German Reparation Payments;
 - (iv) Japanese-American and Aleutian Restitution Payments;
 - (v) Alaska Native Claims Settlement Act exclusions;
 - (vi) State funds paid to crime victims;
 - (vii) Payments made to individuals because of their status as victims of Nazi persecutions;
 - (viii) Payments to children born of Vietnam veterans diagnosed with spina bifida;
 - (ix) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act;
 - (x) Distribution of perpetual judgment funds to Indian tribes under the following:
 - (I) Indian Judgment Funds Distribution (P.L. 93-134)
 - (II) Black Feet and Gros Ventre Tribes (P.L. 92-254)
 - (III) Grand River Band of Ottawa Indiana in Indian Claims Commission Docket No. 40-K;
 - (IV) Tribes of groups under P.L. 93-134;
 - (V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and
 - (VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.
52. Severance – Countable.
53. Sick/Disability Payments – Countable.
54. Social Security Payments – Countable.
55. Social Service Payments – Excluded.
56. Strike Benefits – Countable.
57. Supplemental Nutrition Assistance Program (SNAP) – The value of a SNAP benefit is excluded. The value of free or reduced food under WIC or the National School Lunch Act is also excluded.
58. SSI Payments – Excluded.
59. Temporary Disability Payments – Income is countable as unearned income to the extent it is not a reimbursement for specific costs and is paid directly to the applicant or any member of the

applicant's household.

60. Tips – Any amount over \$20 per month is countable.
 61. Trusts – Money withdrawn from the body of a trust or interest and dividends accrued to the trust and paid to the individual is countable.
 62. Unemployment Compensation – Countable.
 63. U.S. Department of Veterans Affairs Payments – Educational benefits, VA Aid & Attendance, Augmented VA benefits and VA payments from Unusual Medical Expenses are excluded.
 64. VISTA Payments – Countable.
 65. Wages – Countable.
 66. Workers' Compensation – Countable.
 67. WIA Payments – Excluded.
 68. Work Study Payments – Exclude college work study income up to the amount necessary to pay for tuition and mandatory fees. Income in excess of tuition and fee costs is countable earned income.
- (c) Resource Requirements. Resources for individuals described in this paragraph are calculated according to the AFDC cash assistance program's resource definitions and policies (Tenn. Comp. R. & Regs. 1240-01-04-.05, .07, .09 – .10; 42 CFR §§ 435.840 and 435.845; and 45 CFR § 233.20). Individuals described in this paragraph are subject to the following resource requirements:
1. Annuities – Excluded as a resource if it meets the requirements of 42 U.S.C. § 1396p(c)(1)(G). If the annuity is an excluded resource, payments being received from the annuity may be countable unearned income. If the annuity is a countable resource, any payments being received from the annuity are excluded. The countable value is its fair market value.
 2. Business or Self-Employment – Excluded as essential for the production of earned income. Such excluded resources may include:
 - (i) Tools/equipment;
 - (ii) Stock or raw materials;
 - (iii) Personal property essential for income production;
 - (iv) Real property;
 - (v) Office equipment;
 - (vi) Business loans for the purchase of capital assets;
 - (vii) Inventory;
 - (viii) Machinery and equipment;
 - (ix) Business/commercial checking accounts; and
 - (x) Life insurance.

3. Burial Contracts or Policies – Excluded. This does not include pre-paid or pre-need burial agreements.
4. Burial Plot – Exclude the value of burial plots and spaces for all household members.
5. Prepaid Burial Agreements or Burial Trusts – Exclude one burial agreement or burial trust with equity value of \$1500 or less per family member.
6. Cash – Countable.
7. Certificate of Deposit (CD) – Countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining value.
8. Checking Account – Personal checking accounts are countable. Other checking accounts may be excluded if designated for burial needs, educational income, Individual Development Accounts, PASS, prorated as income, proceeds from the sale of a home, disaster or settlement funds and retroactive SSA payments.
9. Contract for Deed or Mortgage – The value of a contract for deed or mortgage may be a countable asset depending on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset:
 - (i) When the individual is the lender for a contract for deed, the lender may sell or transfer the instrument to have immediate access to the unpaid principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. The value of the contract may be excluded from the countable resource if the individual can demonstrate that the contract cannot be sold without his realizing a net loss.
 - (ii) If the individual is the borrower, the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.
10. Educational Income – All educational income is excluded as a resource, including Title IV, Bureau of Indian Affairs, Department of Veterans Affairs and work study for post-secondary education. The individual must be enrolled in school and attending classes to be considered a student. Grants, scholarships, fellowships and gifts other than those previously listed intended to pay for tuition, fees or education expenses are excluded as a resource.
11. Farm, Business or other Equipment – The equity value of non-self-employment income-producing real property, other than the homestead, is countable. If the property is used for self-employment, it is excluded as Business or Self-Employment.
12. Rental property - Countable if the individual who owns the property is not 'in the business of' renting property. Someone who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least 20 hours per week.
13. Home and Lot – The entire value of the home, whether on land or water, and lot and all adjoining land not separated by property owned by others and any related outbuildings are excluded in determining resource eligibility, as long as the home is the principal place of residence for the applicant/enrollee. Temporary absences from the home do not affect the home's exemption, as long as the individual intends to return home at a specified time.
14. Household Goods and Personal Effects – Excluded.

15. Individual Development Account (IDA) – Funds, including accrued interest, in the account are excluded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions to the account.
16. Income-Producing Resource – Countable if accessible to the individual.
17. Sick and Disability Insurance – Excluded.
18. Burial Insurance – Excluded.
19. Items of Unusual Value – Exclude up to \$2,000 of all total personal items of unusual value. If the individual's equity value in one or more than one item of unusual value is greater than \$2,000, the amount that exceeds \$2,000 is countable towards the resource limit.
20. Life Estates:
 - (i) Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title, subject to the following exceptions:
 - (I) A life estate will be excluded as the home when the property meets the home exemption.
 - (II) A life estate will be excluded when ownership is necessary for the production of earned income. See Business and Self-Employment.
 - (III) The terms of the life estate contract prevent the holder from selling his or her interest in the property.
 - (ii) If the life estate is not excluded based on the criteria above, the entire value of the life estate is a countable asset. The life estate value is determined by multiplying the fair market value of the property by the percentage listed in the "Life Estate Interest Table" for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.
21. Life Insurance – Excluded.
22. Livestock – The value of livestock necessary for business or self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. Livestock that is used as non-business, income-producing property is countable.
23. Oil and Mineral Rights – May be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when the surface rights of the same property are countable (non-homestead, real property).
 - (i) If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, then oil and mineral rights are also excluded.
 - (ii) If oil or mineral rights are producing income to the individual, and he or she is not actively engaged in the production of income, the equity value of the rights is countable.
24. Personal – Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and/or his or her family.

25. Personal Consumption – Exclude as a resource the equity value of a non-business property used to produce goods or services essential to daily activities.
26. PASS – Income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.
27. Proceeds from the Sale of a Home – Excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within three (3) months of the date of receipt of the proceeds.
28. Promissory Note and other Loans – A promissory note or other loan given by the household is considered personal property and is countable, unless the note/loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his or her share in the note or loan. The equity value of the note/loan is countable.
29. Prorated as Income – Excluded.
30. Real Property – The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:
 - (i) Property excluded as the homestead;
 - (ii) The inaccessible equity value of real property;
 - (iii) Equity value of income-producing property;
 - (iv) Real property necessary for the production of earned income (see Business or Self-Employment); and
 - (v) Real property excluded under a Conditional Assistance agreement between the individual and the State. The individual must make a bona fide effort to sell the property at its current market value, and repay the State for medical expenses covered by HCFA during the exclusion period with the proceeds of the sale. Exemption of the real property is not to exceed 9 months. Only one parcel of property may be excluded under a Conditional Assistance agreement per period of eligibility.
 - (I) Repayment of medical expenses covered by HCFA may not exceed the total of the net proceeds. Any proceeds remaining after repayment to the State are considered a resource.
 - (II) If the property remains unsold after 9 months, the property is considered inaccessible so long as bona fide efforts to sell the property continue.
31. Retirement Accounts and Pension Plans – Excluded up to \$20,000. Money held in an IRA, 401(K), or Keogh in excess of \$20,000 is countable, minus any penalty for early withdrawal.
32. Savings Account – Countable if it is characterized by personal use. If the current month's income has been deposited into the account, it must be excluded when determining the current value of the account. A savings account may be excluded if it is used for one of the following purposes:
 - (i) Burial funds;
 - (ii) Business or Self-Employment;

- (iii) Educational Income;
 - (iv) Individual Development Account;
 - (v) PASS;
 - (vi) Proceeds from the Sale of a Home (subject to time limits);
 - (vii) Prorated as Income;
 - (viii) Settlement or Disaster Payment, if Excluded by Policy; and
 - (ix) SSI/SSA Retroactive Payment (subject to time limits).
33. Settlement or Disaster Payment – Payments or benefits provided under certain Federal statutes are excluded, if payments are not commingled with other funds. Excluded settlement and/or disaster payments include:
- (i) Agent Orange Settlement Payments. Payments and interest are excluded as unearned income but counted when determining patient liability for institutionalized individuals;
 - (ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;
 - (iii) Distribution of perpetual judgment funds to Indian tribes under the following:
 - (I) Indian Judgment Funds Distribution (P.L. 93-134)
 - (II) Black Feet and Gros Ventre Tribes (P.L. 92-254)
 - (III) Grand River Band of Ottawa Indians in Indian Claims Commission Docket No. 40-K;
 - (IV) Tribes of groups under P.L. 93-134;
 - (V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and
 - (VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.
 - (iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;
 - (v) Filipino Veterans Compensation Fund Payments. Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;
 - (vi) Japanese-American and Aleutian Restitution Payments (and interest from payments);
 - (vii) Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments);
 - (viii) Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments);
 - (ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition

Policies Act of 1970 (interest is not excluded);

- (x) Revenues from the Alaska Native Fund paid under Section 21(a) of the Alaska Native Claims Settlement Act; and
 - (xi) State funds paid to crime victims.
34. SSI/SSA Retroactive Payments – Excluded for 9 months after the payment is received and countable after the 9 month exclusion period.
35. Stocks, Bonds and Mutual Funds – Countable if asset is held for personal use. Stocks, bonds or mutual funds held for purposes listed below are subject to different treatment:
- (i) Burial;
 - (ii) Business or Self-Employment;
 - (iii) Educational Income;
 - (iv) Proceeds from the Sale of a Home;
 - (v) Prorated as Income; or
 - (vi) Settlement or Disaster Payment, if Excluded by Policy.
36. Tools of the trade – Excluded when essential for the production of earned income.
37. Trusts – Countable or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, plus other factors.
38. Vehicles – Exclude up to \$4,600 of the equity value of one vehicle in the applicant's household. The equity value of any other vehicle is countable, unless the vehicle can be excluded based on its use. The equity value of recreational vehicles (boats, snowmobiles, jet skis, ATVs and aircraft) is a countable resource.
- (d) Disregards and Expenses Allowed. For purposes of determining the income of individuals described in this paragraph, the following expenses will be disregarded from their income:
- 1. Child Support Disregard – Disregard \$50 per household per month if a child living in the home receives child support payments (current only) and the family receives TANF benefits.
 - 2. Earned Income Disregard – Disregard \$90 per month from each household member's total earned income.
 - 3. Payments made on Behalf of Dependents within the Home – Disregard up to \$175 per month of day care expenses per dependent age 2 or older. Disregard up to \$200 per month of day care expenses per dependent under age 2.
 - 4. Student Income – Disregard the earnings of a child who is a full-time student or part-time student and not employed full time.
- (e) Household composition for TennCare Medicaid Medically Needy categories is based on the principle of FRR.
- 1. The following individuals must be included in the applicant's household for TennCare Medicaid Medically Needy Child, if living with the applicant:

- (i) The applicant;
 - (ii) The applicant's spouse;
 - (iii) The applicant's children under age 21;
 - (iv) For applicants who are under age 21, the applicant's natural or adoptive parents; and
 - (v) The applicant's siblings who are under age 21(including unborn children).
2. The TennCare Medicaid Medically Needy child applicant's parent(s) are not included if the applicant is an emancipated minor.
 3. A step parent living in the home with a child applicant for TennCare Medicaid Medically Needy is not included in the child's household.
 4. The following individuals must be included in the TennCare Medicaid Medically Needy Qualified Pregnant Woman applicant's household, if living with the applicant:
 - (i) The pregnant woman applicant;
 - (ii) The applicant's unborn child(ren);
 - (iii) The applicant's spouse; and
 - (iv) The applicant's children under age 21.
 5. Parents of a pregnant woman applying for TennCare Medicaid Medically Needy Qualified Pregnant Woman coverage are not included in the applicant's household.
- (f) Spend down.
1. Applicants must produce proof of relevant medical expenses in order to "spend down" monthly income to the TennCare Medically Needy Income Standard (MNIS) to be eligible in a Medically Needy category. If income is below the MNIS, spend down will not be necessary. Applicants may reduce available monthly income with countable expense, as listed below, in order to qualify for eligibility in the Medically Needy categories. The income limits for the Medically Needy category are published in the State Plan.
 2. Countable Expenses. The following rules apply to the expenses that may be used to meet spend down:
 - (i) Countable expenses incurred during the month of application, whether paid or unpaid.
 - (ii) Countable expenses paid during the month of application, regardless of when such expenses were incurred.
 - (iii) Countable expenses incurred during the three calendar months prior to the month of application, whether paid or unpaid.
 - (I) Expenses paid during the three calendar months prior to the month of application will not be counted unless such expenses were also incurred during those three calendar months.
 - (II) Any expenses incurred before the three calendar months prior to the month of application will not be counted unless payment is made on those expenses during the month of application, in which case only the amount paid during the month of

application is counted.

- (III) When a Medically Needy enrollee has been eligible for 12 months, he will be expected to meet spend down again as described in this section, except verified expenses that are documented in the enrollee's Medicaid record can be carried over to the next year as long as the individual remains continuously eligible, the expenses remain unpaid, and the bills are not written off by the provider. Only the portions of expenses that were not previously used to meet spend down can be carried over to the next eligibility determination. If an enrollee loses eligibility at any point, the carryover of unpaid medical expenses ends and the enrollee must meet spend down as if he were a new applicant.
 - (iv) All medical expenses are considered incurred the date the service is provided with the following exception: Medical expenses related to maternity care (e.g., global fee) are considered incurred the month the physician presents a bill once services have begun (i.e., initial examination by the physician at a minimum).
 - (v) If spend down is not met by the medical bills incurred as of the date of application submission or as of the date of submission of a renewal application during redetermination, the daily countable medical expenses incurred during the application month will be added until spend down liability is reached.
3. Incurred or paid expenses for the following individuals may be considered countable expenses for purposes of determining Medically Needy financial eligibility:
- (i) The applicant;
 - (ii) Members of the applicant's household;
 - (iii) The applicants FRRs or anyone for whom the applicant is financially responsible; and
 - (iv) Individuals not living in the applicant's home or eligible for inclusion if the applicant's household member or an applicant's FRR is legally obligated to pay the applicant's medical expenses.
4. Countable expenses are those for which the individual is still liable and that are:
- (i) For medical or remedial care, including costs for over the counter medications and costs incurred for medical insurance premiums, co-payments and deductibles. Health insurance premiums may be deducted as a spend down expense only when payment is due, even if paid in another month;
 - (ii) Verifiable and for which the individual provides substantiation;
 - (iii) Incurred by eligible individuals and are the legal responsibility of a household member and not subject to payment in full or part by a third party;
 - (iv) Recognized under State law but not covered under the State's TennCare Medicaid plan or waiver (continuously eligible individuals); or
 - (v) Covered under TennCare Medicaid but incurred during the spend down period (new applicants).
5. The following list includes but is not limited to the types of medical expenses that are considered Countable Medical Expenses for the Medically Needy categories:
- (i) Acupuncture services.

- (ii) Bed hold at a Long Term Care Facility (Medicaid rate).
- (iii) Dental expenses.
- (iv) Doctor's fees – includes fees from services rendered by practitioners and others providing medical services, physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, and Christian Science providers.
- (v) Drugs prescribed by a physician (prior to TennCare eligibility) – includes charges for medicines and drugs prescribed by a doctor incurred prior to establishing TennCare Medicaid eligibility and which remained unpaid or paid in the month under consideration (i.e., Spend Down month).
- (vi) Guide dogs – Guide dogs for the blind or deaf and the costs of their maintenance.
- (vii) Hospital charges.
- (viii) Medical care charges included in tuition costs – Charges for medical care included in the tuition fee of a college or private school which is paid on a monthly basis, provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.
- (ix) Nursing home costs.
- (x) Nursing services – Nursing services include nursing care in a client's home, if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder and ordered by a physician. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as the preparation of meals and the performance of housework, is not deductible.
- (xi) Organ transplant expenses.
- (xii) Prosthetic devices – Artificial teeth, limbs, hearing aids and component parts, eyeglasses and crutches.
- (xiii) Psychiatric care – Psychiatric care primarily for alleviating a mental illness or defect; the cost of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care.
- (xiv) Special education for handicapped – Special school for mentally or physically handicapped individuals if for the alleviation of handicap. The costs of meals and lodging, if supplied by the institution, and/or ordinary education furnished incidental to the special services are medical expenses.
- (xv) Substance abuse treatment – Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment.
- (xvi) Transportation for medical/remedial purposes – Transportation essential to medical care, e.g., bus, taxi, train, or plane fares, and 47 cents for each mile that the client's car is used for medical purposes, in addition to parking fees and tolls.
- (xvii) Over the counter (non-prescription) medicine – \$10 per month is deducted for these expenses without verification, using only the applicant's statement. All of these expenses must be verified if the amount is more than \$10 per month.

6. The following are types of medical expenses that are not considered Countable Medical Expenses for the Medically Needy categories:
 - (i) Expenses that have been written off as uncollectible or have been forgiven by the provider.
 - (ii) Expenses that are covered by the State's TennCare Medicaid plan and are incurred during a period of eligibility:
 - (I) Costs incurred during a period of TennCare eligibility due to co-pays or services not covered such as dental, hearing and eye care for adults are allowable as a medical expense.
 - (II) Bills incurred during TennCare eligibility which are subject to TennCare reimbursement are not considered outstanding for subsequent spend down periods even if not paid by TennCare.
- (3) ABD Financial Determinations.
- (a) Coverage groups whose financial eligibility is determined based on SSI financial methodology are:
 1. Members of SSI-Related Groups.
 2. MSP Applicants.
 3. Individuals applying for coverage of LTSS, under the Institutional Medicaid category.
 - (b) Income Determinations. Income countable for purposes of individuals described in this paragraph is defined at 20 CFR §§ 416.1100, et seq., and as set forth below. Unless otherwise specified below, these individuals are subject to the following income requirements:
 1. Adoption Subsidies – Countable to the child if intended for general living expenses. Excluded if for reimbursement of child care while the adult responsible for the child is at work or seeking employment, or for medical expenses.
 2. Alimony – Countable.
 3. Annuity Payments – If the underlying annuity is an excluded resource, the periodic payments are countable unearned income. If the underlying annuity is a countable resource, payments are excluded.
 4. Assistance Payment from another State – Countable.
 5. Bonuses – Countable.
 6. Care and Contribution in Exchange for a Transferred Asset – Countable.
 7. Canceled Debts – Excluded.
 8. Capital Gains – Countable.
 9. Cash Support – Countable, unless excluded as irregular or infrequent income.
 10. Child Support Arrearage – Countable.
 11. Child Support Payments – Countable to the child(ren) the payments are intended to support. Exclude one-third (1/3) of the child support payment to or for an eligible child. The one-third

exclusion does not apply to ineligible children.

12. Commissions – Countable.
13. CSIMA – Countable as unearned income only when the institutionalized individual is not in the community spouse's household. If the applicant is a deemed member of the institutionalized individual's household, the CSIMA is excluded.
14. Contractual Payments – Excluded.
15. Death Benefits – Countable income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.
16. DIMA – Countable as unearned income only when the institutionalized individual is not in the dependent's household. If the applicant is a deemed member of the institutionalized individual's household, the DIMA is excluded.
17. Differential Payments – Countable.
18. Domestic Volunteer Service Act Payments – Excluded if received through the following programs: Title II Retired and Senior Volunteer Program, and Foster Grandparent Program; Title III Service Corps of Retired Executives, Senior Companion Program, and Active Corps of Executives.
19. Earned Income Tax Credits – Excluded.
20. Earned In-Kind Food or Shelter – Countable.
21. Earned In-Kind Not Food or Shelter – Excluded.
22. Earned In-Kind Wages – Countable.
23. Education Income that is Not Work Study – Excluded.
24. Farmer/Fishing Income – Countable.
25. Gambling Prizes and Awards – Countable.
26. General Assistance Payments – Countable.
27. Gifts – Countable.
28. Income Not Pursued - Countable.
29. Income Produced from Resources – Income generated by a resource that is excluded is countable unearned income. Income generated by a resource that is countable is excluded as income.
30. Inheritance Cash – Countable.
31. Interest Bearing Resources – Interest earned on a countable resource is excluded as unearned income. Interest earned on an excluded resource is countable as income.
32. Irregular or Infrequent Income – Exclude up to \$60 per calendar quarter of unearned income when it is received infrequently or irregularly. Exclude up to \$30 per calendar quarter of earned income when it is received infrequently or irregularly.

33. Jury Duty Pay – Countable unless the income is turned over to an applicant's employer.
34. Long Term Care Insurance Payments – Countable if the payment is not assigned to the nursing home or lead HCBS agency.
35. Military Allotments – The Family Subsistence Supplemental Allowance (FSSA) and the Military Basic Allowance for Housing (BAH) are counted as unearned income.
36. Older Americans Act Payments – Countable.
37. Payments from FEMA – FEMA payments issued as a result of a presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by States, local governments and disaster assistance organizations are also excluded. FEMA payments which are made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable.
38. Pensions – Countable.
39. PASS Payments – Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his or her own use is countable income to the protective payee. Even if the protective payee retains a fee for his or her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.
40. Rental or Lease Income – Countable as earned income when the individual is in the business of renting or leasing property, i.e., self-employment. Countable as unearned income when the individual is not in the business of renting or leasing property. Count the amount of income remaining after expenses related to maintaining the property are applied.
41. Royalties and Honoraria – Countable.
42. Self-Employment – Net earnings are countable.
43. Settlements or Disaster Payments – The following settlements and disaster payments are excluded as unearned income:
 - (i) Agent Orange Settlement Payments. Payments and interest are excluded as unearned income but counted when determining patient liability for institutionalized individuals;
 - (ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;
 - (iii) Distribution of perpetual judgment funds to Indian tribes under the following:
 - (I) Indian Judgment Funds Distribution (P.L. 93-134)
 - (II) Black Feet and Gros Ventre Tribes (P.L. 92-254)
 - (III) Grand River Band of Ottawa Indiana in Indian Claims Commission Docket No. 40-K;
 - (IV) Tribes of groups under P.L. 93-134;
 - (V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

- (VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.
 - (iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;
 - (v) Filipino Veterans Compensation Fund Payments. Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;
 - (vi) Japanese-American and Aleutian Restitution Payments (and interest from payments);
 - (vii) Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments);
 - (viii) Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments);
 - (ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded);
 - (x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and
 - (xi) State funds paid to crime victims.
44. Severance – Countable.
 45. Sheltered Workshop Payments – Excluded.
 46. Sick/Disability Payments – Countable.
 47. Social Security Payments – Countable.
 48. Social Service Payments – Excluded.
 49. SSI – Excluded.
 50. Temporary Disability Insurance – Income is countable as unearned income to the extent it is not a reimbursement for specific costs and is paid directly to the household.
 51. Tips – Any amount over \$20 per month is countable.
 52. Trusts – Dividends, interest, rents and other income generated by a trust fund, unless otherwise excluded, that can be paid to the beneficiary or to a third party on the beneficiary's behalf are countable income to the beneficiary for the period the fund is intended to cover, beginning the month the funds become available, regardless of whether the income is actually paid out to the beneficiary. When funds are withdrawn irregularly, the payments are countable in the month received.
 - (i) Monies withdrawn from the principal of an accessible (countable) trust fund are excluded as income to the beneficiary, because an accessible trust fund is a countable resource. Money cannot be considered income and a resource in the same month.
 - (ii) Monies disbursed from the principal of an inaccessible trust fund are counted as income

because an inaccessible trust fund is an excluded resource.

- (iii) Monies received by the trustee of a trust and used for the care and maintenance of a third party beneficiary (adult or child) are excluded as income for the trustee.
- 53. Unearned In-Kind Income or In-Kind Support and Maintenance – Unearned In-Kind income in the form of food and/or shelter may be countable or excluded and is subject to certain rules that determine the countable or excluded value.
 - 54. Unearned In-Kind Income, Not Food or Shelter – Excluded.
 - 55. Unemployment Compensation – Countable.
 - 56. U.S. Department of Veterans Affairs Payments:
 - (i) Additional Child Allotment – Excluded.
 - (ii) Compensation – Countable.
 - (iii) Death Benefit – Countable as unearned income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.
 - (iv) Dependency and Indemnity Compensation – Countable.
 - (v) Pension – Veteran's benefits other than Aid and Attendance (A&A) are countable income. Homebound allowances are countable income. Any part of a veteran's pension that is attributable to A&A is excluded as income, but is treated as third party liability available to help meet the veteran's medical expenses. A&A will be contributed to the cost of care in the nursing home.
 - (vi) If an institutionalized veteran receives the \$90 reduced, improved pension, exclude the \$90 from countable income and the cost of care calculation.
 - 57. VISTA Payments – Excluded.
 - 58. Wages – Countable.
 - 59. Worker's Compensation – Excluded.
 - 60. WIA Payments – Excluded.
 - 61. Work Study Payments – Excluded.
- (c) Resource Determinations. Resources countable for purposes of individuals described in this paragraph are defined at 20 CFR §§ 416.1201, et seq. Unless otherwise specified below, individuals described in this paragraph are subject to the following resource requirements:
- 1. Annuities.
 - (i) Annuities are countable resources when:
 - (I) The annuity is owned by the individual receiving or applying for TennCare Medicaid or an ABD eligible spouse but the annuity payments are made to someone else;
 - (II) The individual does not own 100% of the annuity (or the individual and his or her spouse do not own 100% of the annuity);

- (III) The annuity is owned by an ABD ineligible spouse or a community spouse;
 - (IV) The annuity is owned by a deemed parent and it is not an employment related annuity; or
 - (V) The annuity does not meet any of the conditions described in subpart (iii) items (I)-(VI) below.
- (ii) If an annuity meeting any of the conditions in subpart (i) is found to be legally inaccessible, it must be reviewed under the transfer of assets policy for individuals applying for long term services and supports.
 - (iii) Annuities owned by the individual or an ABD-eligible spouse are excluded resources if the annuity meets all of the following conditions:
 - (I) The annuity is irrevocable;
 - (II) The annuity is non-assignable;
 - (III) The annuity is annuitized;
 - (IV) The annuity is actuarially sound;
 - (V) The payment contract requires periodic payments of equal amounts;
 - (VI) Periodic payments are provided to the annuitant: and
 - (VII) The individual owns 100% of the annuity, or the individual and his or her ABD eligible spouse together own 100% of the annuity.
2. Business or Self Employment – Excluded as essential for the production of earned income. Resources may include:
- (i) Tools/equipment;
 - (ii) Stock or raw materials;
 - (iii) Personal property essential for income production;
 - (iv) Real property;
 - (v) Office equipment;
 - (vi) Business loans for the purchase of capital assets;
 - (vii) Inventory;
 - (viii) Machinery and equipment;
 - (ix) Business/commercial checking accounts; and
 - (x) Life insurance.
3. Burial Funds.
- (i) Burial funds which are not commingled are excluded resources when:

- (I) The funds are used to purchase a life insurance policy which is then irrevocably assigned to a funeral provider. Either the ownership of the policy or proceeds may be assigned to the funeral provider. The purpose of the assignment is to fund a burial contract.
 - (II) The funds are invested in an irrevocable pre-paid or pre-need burial contract established by a funeral provider and the contract meets the following conditions:
 - I. Both the individual and the funeral home representative have signed the document;
 - II. An itemized list of the services provided under the contract is provided;
 - III. The total dollar amount of the agreement is specified;
 - IV. The individual was neither a minor nor legally declared incompetent when the agreement was signed; and
 - V. The agreement specifies in writing that the money is not refundable under any circumstances.
 - (III) The funds are invested in a burial trust established by the individual, and the total funds in the trust, including interest payments, do not exceed \$6,000 per individual. Transport costs which cause the trust value to exceed \$6,000 are excluded.
- (ii) Burial funds are countable resources when:
- (I) The funds are used to purchase a life insurance policy and a revocable assignment of the policy or proceeds is made to a funeral provider.
 - (II) The funds are invested in a revocable pre-paid or pre-need burial contract established by a funeral provider.
 - (III) Countable burial funds are eligible to be excluded as part of the individual's burial reserve.
- (iii) Burial Reserve – An individual is allowed to set aside \$1,500 in resources to cover expenses connected to his or her burial, cremation or other funeral arrangements. Funds allowed to be excluded as part of the burial reserve include revocable, countable burial funds. These funds must not be commingled with other resources, and must be set aside for burial expenses. The \$1,500 maximum amount of the burial reserve is first reduced by:
- (I) Life insurance, if the total value of all life insurance owned by the individual is \$1,500 or less; and
 - (II) Funds in an irrevocable burial agreement or contract.
4. Burial Plots – Exclude the value of one burial space for each family member, e.g. spouse, child, parent, sibling, whether living in the home or not. Burial plots and spaces include a gravesite, crypt, mausoleum, niche or other repository for bodily remains, vaults, headstones, markers, plaques, containers and arrangement for opening and closing the gravesite.
 5. Cash – Countable.
 6. Certificates of Deposit (CD) – Countable if held in a personal account. The value of a CD is the

net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining net value.

7. Checking Accounts – Personal checking accounts are countable. Some checking accounts that may be excluded include those designated for burial needs, educational income, Individual Development Accounts, PASS, prorated as income, proceeds from the sale of a home, disaster or settlement funds if excluded by policy, and retroactive SSA payments.
8. CCRC Deposit or Fee – The value of an entrance fee paid to a CCRC is a countable resource when it meets the following conditions:
 - (i) The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;
 - (ii) The entrance fee or its remaining portion is refundable when the individual dies or terminates the contract and leaves the CCRC; and
 - (iii) The entrance fee does not confer any ownership interest in the community.
9. Contracts for Deed or Mortgage – The value of a contract for deed or mortgage may be a countable asset dependent on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset.
 - (i) When the individual is the lender for a contract for deed, the lender may sell or transfer the instrument to have immediate access to the unpaid principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. The value of the contract may be excluded from the countable resources if the individual can demonstrate that the contract cannot be sold without his realizing a net loss.
 - (ii) If the individual is the borrower the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.
10. Educational Income.
 - (i) Educational income received under Title IV, Bureau of Indian Affairs, or Department of Veterans Affairs programs is excluded as a resource.
 - (ii) Grants other than Title IV or Bureau of Indian Affairs grants, scholarships, fellowships and gifts intended to pay for tuition, fees or educational expenses are excluded for 9 months beginning the month after the funds are received. The individual must be enrolled in school and attending classes to be considered a student.
11. Farm, Business, Other Equipment – The equity value of non-self-employment income-producing real property, other than the homestead, is a countable resource. Exclude up to six thousand dollars (\$6,000) in equity and count only the amount that exceeds the limit, if the net income totals at least six percent (6%) of the equity value. If the property is used for self-employment, it is excluded as Business or Self-Employment.
12. Rental property is countable if the individual who owns the property is not in the business of renting property. Someone who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least 20 hours per week.
13. Homestead Exclusion - The entire value of the home, whether on land or water, all adjoining land not separated by property owned by others and any related outbuildings are excluded in

determining resource eligibility as long as:

- (i) The home is the principal place of residence for the client and/or his spouse and/or dependent relatives; and
 - (ii) If the individual resides in a long-term care facility, his intent to return to the home is established.
 - (iii) For an institutionalized individual, the home is excluded if the above are true and the individual's equity interest does not exceed \$552,000, with one exception: the home equity limit does not apply to an institutionalized individual if the spouse of the individual, the individual's child under age 21, or a blind or permanently and totally disabled child is residing in the home. An institutionalized individual whose home exceeds the \$552,000 limit and who does not have a spouse, a child under age 21 or a disabled or blind child living in the home, is not eligible for payment of long term services and supports, unless it is determined undue hardship exists.
 - (iv) An individual must have lived in the home for it to be considered his or her home or principal place of residence.
 - (v) The value of the home and surrounding land will not be counted as a resource during the individual's absence from an unoccupied home when he or she intends to return to the property. An absence from the home can be necessary to accomplish a specific purpose such as hospitalization, confinement in a nursing home or receipt of services, such as nursing or personal care services not available to the individual in his or her home.
 - (vi) An intent to return home is nullified by any efforts to sell or dispose of the property during the exemption period. The exemption based on the intent to return ends the first day of the month after the month efforts are made to sell or dispose of the homestead property.
 - (vii) Rental of a homestead which has been excluded because of intent to return does not nullify the exclusion. The homestead retains the exclusion as long as there is a clear, non-contradictory intent to return, and no efforts are made to sell or dispose of the property. The rent will be counted as unearned income in the month received.
 - (viii) The exemption based on residence of the enrollee's dependent relative ends the first day of the month after the relative last lived in the homestead, if the relative does not intend to return. Real property located outside of Tennessee can be excluded from countable resources as homestead property, if there is substantiation of the individual's intent to return to the home or the property is the principal residence of the individual's spouse or dependent relatives.
14. Individual Development Account – Funds, including accrued interest, in the account are excluded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions into the account.
15. Income-Producing Resource - Exclude up to \$6,000 of an individual's equity in an income-producing resource if it produces a net annual income to the individual of at least 6 percent (6%) of the property's equity value. If the individual's equity value is greater than \$6,000, the amount that exceeds \$6,000 is countable towards the resource limit.
- (i) If an income-producing resource does not produce a net annual income of at least 6 percent (6%) of the resource's equity value, the entire equity value of the resource is countable.
 - (ii) If the individual owns more than one piece of income-producing resource and each produces income, each is reviewed to determine whether the 6 percent (6%) test is met.

Then the amounts of the individual's equity in all of those properties producing 6 percent (6%) are totaled to determine if the total equity of all properties is \$6,000 or less. If the total equity value in the properties that meet the 6 percent (6%) rule is over the \$6,000 equity limit, the amount exceeding \$6,000 is counted as a resource.

16. Insurance – Exclude Sick and Disability Insurance and Burial Insurance.
17. Items of Unusual Value, Household Goods, and Personal Effects – In general, an item may be considered an item of unusual value if the item is not excluded as a household good or personal effect, and the equity value of the item is greater than \$500. An item of unusual value that generates income for the individual is countable. The countable value is determined by applying the Rate of Return test (see Income-Producing Resource above). A personal item of unusual value is excluded. Household Goods and Personal Effects are also excluded.
18. Life Estates – Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title, subject to the following exceptions:
 - (i) A life estate will be excluded as the home when the property meets the homestead exemption.
 - (ii) If the property is used in the passive production of income, then the life estate is subject to the Rate of Return test (see, Income-Producing Resource above).
 - (iii) A life estate will be excluded when ownership is necessary for the production of earned income.
 - (iv) The terms of the life estate contract prevent the holder from selling his or her interest in the property.
 - (v) If the life estate is not excluded based on the criteria (i)-(iv) above, the entire value of the life estate is a countable asset. The life estate value is determined by multiplying the Fair Market Value (FMV) of the property by the percentage listed in the SSA's Life Estate and Remainder Interest Tables for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.
 - (vi) When an individual purchases, or, in some other way receives, as compensation in a transaction, a life estate in another individual's home, the purchase of the life estate is considered an asset transfer subject to penalty, unless the individual then lives in the home for a period of at least one year after receiving the life estate.
 - (vii) If the individual does live in the home for a period of one year after receiving or purchasing the life estate, then the amount of the transfer is the entire amount used to purchase the life estate.
 - (viii) If an individual purchases a life estate in another individual's home and then does live there for one year after the purchase, the life estate is an excluded resource while being used as the individual's (or the individual's spouse's) home. However, if payment for a life estate exceeds the FMV of the life estate the difference between the amount paid and the FMV should be treated as an asset transfer. In addition, if an individual makes a gift or transfer of a life estate interest, the value of the life estate should be treated as a transfer of assets.
19. Life Insurance – Countable or excluded based on the type of life insurance owned by the individual and its intended use. Exclude all life insurance if the total face value of all policies does not exceed \$1,500 per owner.

20. Livestock – The value of livestock necessary for business or self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. The equity value of livestock that are pets is countable. Livestock that is used as non-business income-producing property is countable, and subject to treatment as an Income-Producing Resource as described in this subparagraph.
21. Oil and Mineral Rights – May be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when the surface rights of the same property are countable (non-homestead, real property).
 - (i) If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, the oil and mineral rights are excluded.
 - (ii) If oil or mineral rights are producing income to the individual, and he or she is not actively engaged in the production of income, the equity value of the rights is subject to the Rate or Return test. See Income-Producing Resource above.
22. Patient Trust Account – The balance of the account at the time of application and redetermination is a countable resource.
23. Personal – Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and his or her family.
24. Personal Consumption – Exclude up to \$6,000 of the equity value of non-business property currently in use to produce goods or services essential to daily activities. Any portion of the property's equity value in excess of \$6,000 is a countable resource.
25. PASS - Any income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.
26. Prepayment of Rent – Countable unless the individual cannot receive the money back under any circumstances (i.e., the lease agreement includes a no refund policy, or the landlord provides a statement that the funds will not be returned to the renter). Prepayment of an applicant's mortgage is not considered a resource.
27. Prepayment of Nursing Home Care – Prepayment for care deposited by an applicant upon his admission to a TennCare Medicaid-participating long-term care facility is a countable resource for the individual who is subsequently approved for TennCare Medicaid benefits if the deposit was paid from the individual's own funds.
28. Proceeds from the Sale of a Home - Excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within three (3) months of the date of receipt of the proceeds.
29. Promissory Notes and other Loans – A promissory note or other loan given by the household is considered personal property and is countable, unless the note/loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his or her share in the note or loan. The equity value of the note/loan is countable.
 - (i) If a household makes a loan that is considered inaccessible, or is shown to have a significantly lower market value than the unpaid balance of the loan, the loan will be considered to be an uncompensated transfer of assets. The uncompensated asset transfer will be considered to be the outstanding balance due on the loan as of the date

- of the lender's application for long term services and supports (nursing facility or HCBS services).
- (ii) In addition, the Deficit Reduction Act of 2005 (DRA) provides that funds used to purchase a promissory note, loan or mortgage must meet the following criteria, or else the purchase will be treated as a transfer of assets for less than FMV:
 - (I) The repayment term must be actuarially sound (as determined by SSA standards);
 - (II) Payments must be made in equal amounts during the term of the loan with no deferral payment and no balloon payments; and
 - (III) The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.
 - (iii) If the above criteria are not met, the purchase of the promissory note or loan must be treated as a transfer of assets. The amount used to calculate a penalty will be the outstanding balance of the loan due as of the date of application for TennCare Medicaid.
 - (iv) Promissory notes that are made for purposes other than personal use are treated according to their use. Promissory notes may be made for the following purposes:
 - (I) Burial;
 - (II) Business or Self-Employment; and
 - (III) Proceeds from the Sale of a Home.
30. Property that represents government authority to engage in an income-producing activity – Excluded if the property is used in trade, business or non-business income-producing activity. Exclude property that is currently not in use due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.
31. Prorated as Income – Excluded.
32. Real Property – The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:
- (i) Property excluded as homestead;
 - (ii) The inaccessible equity value of real property;
 - (iii) Equity value of income-producing property (subject to the Rate of Return test);
 - (iv) Real property necessary for the production of earned income (see Business or Self-Employment); and
 - (v) Property excluded under a Conditional Assistance agreement between the individual and the State.
33. Retirement Accounts and Pension Plans – If retirement benefits are being received out of such accounts, the principal is not considered a resource. If payments are not being received and the account is accessible, then the equity value is countable. The equity value is the cash surrender value minus any early withdrawal penalty.
- (i) Funds held in a 401(k) retirement account are countable when the individual or his or her spouse is no longer job-attached because the funds are accessible after employment

- terminates. If the individual is still job-attached, the value of the 401(k) is excluded. A 401(k) retirement account owned by a deemed spouse or a deemed parent is excluded as a resource.
- (ii) Funds held in an IRA are considered accessible to the individual or community spouse. Count the equity value of an accessible IRA when determining eligibility. IRA funds owned by a community spouse are also considered countable and accessible when determining a CSRMA. IRA funds owned by a deemed spouse (for non-institutional categories) or deemed parent are excluded from the resource determination.
 - (iii) Keogh plans are considered accessible and counted as resources to the individual or community spouse even if the household is not actually accessing the funds. Keogh funds are countable resources in determining the CSRMA. Keogh plans owned by a deemed spouse (non-institutional Medicaid) or deemed parent are excluded as resources.
34. Savings Accounts – Countable if it is characterized by personal use. If the current month's income has been deposited into the account it must be excluded when determining the current value of the account. A savings account may be excluded if it is used for one of the following purposes:
- (i) Burial funds;
 - (ii) Business or Self-Employment;
 - (iii) Educational Income;
 - (iv) Individual Development Account;
 - (v) PASS;
 - (vi) Proceeds from the Sale of a Home (subject to time limits);
 - (vii) Prorated as income;
 - (viii) Settlement or Disaster Payment, if excluded by policy; and
 - (ix) SSI/SSA Retroactive Payment (subject to time limits).
35. Settlement or Disaster Payment - Payments or benefits provided under certain Federal statutes are excluded, if payments are not commingled with other funds. Excluded settlement and/or disaster payments include:
- (i) Agent Orange Settlement Payments;
 - (ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;
 - (iii) Distribution of perpetual judgment funds to Indian tribes under the following:
 - (I) Indian Judgment Funds Distribution (P.L. 93-134);
 - (II) Black Feet and Gros Ventre Tribes (P.L. 92-254);
 - (III) Grand River Band of Ottawa Indians in Indian Claims Commission Docket No. 40-K;
 - (IV) Tribes of groups under PL 93-134;

- (V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 94-433); and
 - (VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL 94-114.
- (iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments made to hemophilia patients infected with HIV through blood plasma products as a result of the class action lawsuit;
 - (v) Filipino Veterans Compensation Fund Payments. Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;
 - (vi) Japanese-American and Aleutian Restitution Payments;
 - (vii) Payments made to individuals because of their status as victims of Nazi persecutions;
 - (viii) Payments to children born of Vietnam veterans diagnosed with spina bifida;
 - (ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (State and local payments are only excluded for 9 months);
 - (x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and
 - (xi) State funds paid to crime victims (excluded for 9 months).
36. SSI/SSA Retroactive Payment – Excluded for nine months after the payment is received and counted after that nine month exclusion period.
37. Stocks/Bonds/Mutual Funds– Countable. Although personal mutual funds are countable, those held for purposes listed below are subject to different treatment:
- (i) Burial;
 - (ii) Business or Self-Employment;
 - (iii) Educational Income;
 - (iv) Proceeds from the Sale of a Home;
 - (v) Prorated as Income; or
 - (vi) Settlement or Disaster Payment, if excluded by policy.
38. Tools of the Trade – Excluded.
39. Trusts – Countable or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, plus other factors.
40. Vehicles – One car, truck, motorcycle, camper, motor home, aircraft, snowmobile, watercraft, boat, or all-terrain vehicle is excluded regardless of its value if it is used for transportation of the individual or a member of his or her household. If an applicant owns more than one vehicle, the equity value of that second vehicle is countable when it is owned by the applicant or a deemed filing unit member, and it cannot be excluded under another provision. Boats, motorcycles,

snowmobiles, jet skis, ATVs, and aircraft are generally considered recreational vehicles. The equity value of these recreational vehicles is a countable resource unless it can be excluded under other provisions.

- (d) Conditional Assistance. Real and personal property, which is not exempt under another resource provision, is exempt as a resource if the individual enters into a Conditional Assistance agreement with the State. The individual must make a bona fide effort to sell the property at its current market value, and repay the State for medical expenses covered by HCFA during the period of conditional assistance.
1. The exclusion period for real property is not to exceed 9 months. The exclusion period for personal property is not to exceed 3 months, however a 3 month extension may be granted if the individual is able to show a good cause for failure to dispose of the property. Property that remains unsold at the end of the exclusion period will be considered inaccessible so long as the individual continues the bona fide effort to sell.
 2. Repayment of medical expenses covered by HCFA during the period of conditional assistance may not exceed the total net proceeds of the sale. Any proceeds remaining after the repayment of medical expenses is paid are considered a resource.
- (e) Disregards and Expenses Allowed. Unless otherwise specified in Subparagraph (f) below, individuals described in Subparagraph (a) are subject to the following expense requirements.
1. Court Ordered Child Support Payments – Exclude amount actually paid up to the full court-ordered obligation. A child support disregard will not be allowed for the same individual for whom a CSIMA or DIMA is allowed in an Institutionalized Medicaid budget.
 2. Legally Obligated Alimony Payments – Alimony is an expense to the payer of the alimony and is allowed when alimony is paid during the month of application. The payments must be in cash, including checks and money orders, to be considered alimony. The following payments are not alimony: child support, noncash property settlements, and payments to keep up the payer's property. Alimony expenses do not include voluntary payments.
 3. General Income Disregard – A \$20 monthly General Income Disregard is allowed per household, and is applied to unearned income. If any of the \$20 disregard is not offset by unearned income, the remainder is applied to the spouse's unearned income and then to the applicant or enrollee's earned income.
 4. Child Support Disregard – If the applicant receives child support payments (current only), exclude up to \$50 per month of child support payments received if the family also receives TANF benefits.
 5. Earned Income Disregard – The first \$65 of the earned income of each aged, blind or disabled individual is disregarded.
 6. Blind and Disability Related Work Expenses:
 - (i) The gross countable earned income of each blind or disabled individual (not living in a medical institution) may be reduced by the amount of expenses attributable to earning the income. The allowable Blind Work Expenses (BWE) and allowable Disability Related Work Expenses (DRWE) are not the same. BWE and DRWE apply only to earned income. In order to deduct either BWE or DRWE, the individual must be:
 - (I) Blind, blind and disabled, or disabled; and under age 65, or
 - (II) Age 65 and older; and received SSI payments due to blindness or disability the month before attaining age 65.

- (ii) These expenses do not apply to the Institutionalized Medicaid categories. Work expenses must not be payable or reimbursable by a third party, such as Medicaid, Medicare or other insurance.
7. One-Half Disregard – If an individual's gross earned income, less any of the following disregards: General Income Disregard (\$20) remainder, Earned Income Disregard (\$65), Disabled Work Expense and Impairment-Related Work Expenses (IRWE), is greater than \$0, disregard one-half (1/2) of the remainder.
 8. Student Earned Income Exclusion (SEIE) – Applies to the earnings of an individual who is under age 22 and regularly attending school. The exclusion may apply to an eligible or ineligible individual, child, spouse, or parent(s). The SEIE monthly amount is determined by the SSA. The SEIE does not apply to children attending elementary school.
- (f) Household Composition Rules – Household composition for the ABD categories is governed by the FRR principle. Financial responsibility is limited to spouse to spouse and parent to child. Household composition not only determines which income standard to use, but also how FRR income is "deemed" or available, and the amount of income "deemed" or available to an individual. See 20 CFR §§ 1160, et seq.
1. The following individuals must be included in the applicant's household, if living in the same household:
 - (i) The applicant's spouse;
 - (ii) The applicant's children under 18 years of age or under 22 years of age if a student;
 - (iii) The applicant's parents, for children under 18 years of age or under 22 years of age if a student; and
 - (iv) The applicant's siblings that are under 18 years of age or under 22 years of age if a student.
 2. Step-children are included in the household when they live in the home and their natural parent is the spouse of the applicant and living in the home. Step-parents are included when they live in the home with the applicant and natural or adopted parent, and are married to the natural or adopted parent. Step-siblings are included when their natural or adopted parent lives in the home and is considered the applicant's step-parent.
 3. Financial eligibility is determined based on a household size of one or two. Included household members are the applicant and if applicable, his or her spouse. If there are additional household members, they will be considered in deeming budgets, if appropriate.
 4. Parent-to-child deeming applies when a blind or disabled child is living with his parent(s), and a portion of the parent's income and resources may be deemed available to the child and counted as unearned income to the child in determining his TennCare Medicaid eligibility. The parent receives income disregards and allocations in order to meet his own needs and the needs of other children that live in the household. Child and parental allocations are deducted from the parent's income before any income is deemed to the applicant/enrollee. Parental deeming applies to the following TennCare Medicaid categories:
 - (i) Medicare Savings Program (QMB, SLMB, Q11 and QDWI);
 - (ii) Pickle Passalong Aged and Blind/Disabled.
 - (iii) Institutional Medicaid Aged and Blind/Disabled.

5. The countable income and resources of an applicant/enrollee's TennCare Medicaid-ineligible spouse living in the home may be deemed available to the applicant/enrollee. Spousal deeming only applies when the spouses share a living arrangement, i.e., live in the community or home together. Spousal deeming applies to the following TennCare Medicaid Categories:
 - (i) Medicare Savings Program (QMB, SLMB, QI, and QDWI); and
 - (ii) Pickle Passalong Aged and Blind/Disabled.
 6. The countable income and resources of a long-term services and supports applicant/enrollee's TennCare Medicaid-ineligible spouse living in the home is made available to the applicant/enrollee under the Spousal Impoverishment rules.
- (g) Qualifying Income Trusts (QIT) for Institutional Applicants.
1. Individuals who are receiving or will receive nursing facility services or home and community based services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and whose income exceeds the Medicaid Income Cap (MIC) may establish a qualified income trust. Funds placed in a QIT that meets the standards set forth below are not treated as available resources or income for purposes of determining the individual's TennCare eligibility.
 2. A QIT is a trust consisting only of the individual's pension income, Social Security Income, and other monthly income that is created for the purpose of establishing income eligibility for TennCare coverage when an individual is or soon will be confined to a nursing facility, HCBS or ICF/IID waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program.
 3. An individual is eligible to establish a QIT if his or her income is above the level at which he or she would be financially eligible for nursing facility, HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, or ICF/IID care under Medicaid.
 4. The amount of income that an applicant/recipient places in a QIT cannot be limited nor can it be counted when testing income against the MIC. However, it is used in determining patient liability during post-eligibility treatment of income. If the applicant/recipient's income that is not placed in a QIT is over the MIC, the individual is not financially eligible for the Institutional category.
 5. A valid QIT must meet the following criteria:
 - (i) The trust must be irrevocable and cannot be modified or amended in whole or in part by the Grantor at any time. However, the Trustee or a court of competent jurisdiction shall have the right and jurisdiction to modify any provision of the trust to the extent necessary to maintain the eligibility of the Grantor for medical assistance.
 - (ii) Each month the trustee shall distribute the entire amount of income transferred into the Trust except for an amount not to exceed \$20 for expenses of the Trust.
 - (iii) The sole beneficiaries of the Trust are the individual for whose benefit the Trust is established and the State of Tennessee. The Trust terminates upon the death of the individual, or when the Trust is no longer required to establish TennCare Medicaid eligibility in the State of Tennessee, or if nursing facility care or HCBS is no longer medically necessary for the individual, or if the individual is no longer receiving such services.
 - (iv) The Trust must provide that upon the death of the individual or termination of the Trust,

whichever occurs sooner, the State of Tennessee shall receive all amounts remaining in the Trust up to the total amount of medical assistance paid by the State on behalf of the individual.

- (v) Amounts remaining in the Trust that are owed to the State must be paid to HCFA within three months after the death of the individual or termination of the Trust, whichever is sooner, along with an accounting of the payments from the Trust. HCFA may grant an extension if a written request is submitted within two months of the termination of the Trust.
- (vi) This Part applies to an income trust established on or after July 1, 2005, and under the hardship provision in Section 1613 (e) of the Social Security Act (42 U.S.C. § 1382b(e)). Hardship may be considered to exist when the institutionalized individual or his or her spouse would have resources in excess of the resource limit, is otherwise eligible, and for whom TennCare Medicaid ineligibility would result in loss of essential nursing care which is not available.
- (vii) Allowable payments from the Trust include:
 - (I) Personal Needs Allowance (PNA) – The amount the individual is allowed to retain for his or her personal needs under TennCare Medicaid policies. As of January 1, 2005, this amount is \$50 for confinement in a nursing facility or ICF/IID and 300% of the SSI/FBR for HCBS enrollees and Self-Determination Waiver; and 200% of the SSI/FBR for the Arlington and Statewide Waivers.
 - (II) A deduction of up to \$20 for expenses necessary for managing the trust (i.e. bank charges).
 - (III) CSIMA or DIMA, if applicable.
 - (IV) Health Insurance Premiums – Allowed when the individual has health insurance other than TennCare Medicaid (for example, Medicare premium or a Medicare supplement policy).
 - (V) Item D deductions – Payment for types of medical or remedial care recognized under State law, but not covered as medical assistance under TennCare Medicaid.
- (viii) Any countable income not placed in the QIT and any Trust income remaining after allowable deductions are made shall be paid monthly to the nursing facility, HCBS provider, or MCO by the individual or from the Trust in an amount not to exceed the Medicaid reimbursement rate. Any excess income not distributed from the Trust shall accumulate in the Trust monthly.
- (ix) No other deductions or expenses may be paid from the Trust. Expenses which cannot be paid from the Trust except as specifically provided herein include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past due medical bills and other debts.

(h) Annuities

1. General Rule. Annuities may be counted as a resource or as unearned income, depending on the circumstances of the annuity. If an annuity is determined to be a countable resource, then any payments from the annuity will be excluded as unearned income. If an annuity is an excluded resource, the annuity payments received will be counted as unearned income.
2. Disclosure. Disclosure of annuities is required for all applicants pursuant to 42 U.S.C. §

1396p(e).

- (i) If an individual or his or her spouse refuses to disclose information related to an annuity, the individual will be denied Medicaid eligibility based on the individual's failure to cooperate.
 - (ii) Annuities owned or purchased by individuals applying for long term services and supports are subject to additional requirements. The Deficit Reduction Act of 2005 (DRA) provides that any individual applying for LTSS must:
 - (I) Disclose any interest that he or she or his or her spouse has in an annuity;
 - (II) Name the State of Tennessee as the primary remainder beneficiary on all annuities; and
 - (III) Demonstrate that the purchase or conversion of any annuity which is an excluded resource was not a transfer of assets for less than fair market value (FMV).
3. Value of an Annuity. The value of an annuity is determined by multiplying the total annual payments by the period of the annuity remaining on the date for which value is being determined. If the period of the annuity is based on an annuitant's lifetime, the annual payments are multiplied by the annuitant's life expectancy, see SSA's Period Life Table. If the annuity is a "period certain" annuity, then annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. A letter from the annuity company stating that the annuity has no value is simply a statement of the company's contractual obligations regarding cash value and is irrelevant to the true market value of the annuity. The calculated value of an annuity may be rebutted by providing verified purchase offers from sources in the legitimate business of buying annuities.
4. Treatment as a Resource.
- (i) An annuity is exempt as a resource if it meets the requirements of 42 U.S.C. § 1396p(c)(1)(G).
 - (ii) An annuity is countable as a resource when:
 - (I) The annuity is owned by the individual receiving or applying for TennCare Medicaid or an ABD-eligible spouse, but the annuity payments are made to someone else;
 - (II) The individual does not own 100% of the annuity (or the individual and his spouse do not own 100% of the annuity);
 - (III) The annuity is owned by an ABD ineligible spouse or a community spouse;
 - (IV) The annuity is owned by a deemed parent and it is not an employment related annuity; or
 - (V) The annuity does not meet any of the conditions described in Subpart (iv) below.
 - (iii) If an annuity meeting any of the above conditions is found to be legally inaccessible, it must be reviewed under the transfer of asset policy for individuals applying for long term services and supports.
 - (iv) An annuity owned by the individual or an ABD-eligible spouse is excluded as a resource if the individual alone or the individual and his ABD-eligible spouse together own 100% of the annuity and the annuity meets all of the following conditions:

- (I) The annuity is irrevocable;
 - (II) The annuity is non-assignable;
 - (III) The annuity is annuitized;
 - (IV) The annuity is actuarially sound; and
 - (V) The payment contract requires period payments of equal amounts.
5. Treatment of Annuities Under Transfer of Assets Requirements. The Deficit Reduction Act provides that individuals applying for Institutionalized Medicaid must also comply with additional requirements related to annuities that are purchased on or after February 8, 2006. In addition, certain transactions, referred to as conversions, made to annuities purchased prior to February 8, 2006, will make the annuity subject to the DRA provisions. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity and elections to annuitize the contract. Routine changes, change of address or notification of death or divorce of a remainder beneficiary, made to annuities purchased prior to February 8, 2006, do not subject the annuity to the DRA provisions.
- (i) Disclosure of Interest in an Annuity.
 - (I) Individuals applying for long term services and supports must disclose information regarding any interest that the individual or his spouse may have in an annuity. This disclosure requirement applies regardless of whether the annuity is counted as a resource.
 - (II) If an individual or his spouse refuses to disclose information related to an annuity, the individual will be denied Medicaid eligibility based on the individual's failure to cooperate.
 - (ii) Requirement to name the State as the Remainder Beneficiary.
 - (I) Annuities purchased or converted by the individual or his spouse on or after February 8, 2006, must be changed prior to TennCare Medicaid approval or redetermination to name the State of Tennessee as the remainder beneficiary of the annuity, in the following order:
 - I. Community spouse.
 - II. A minor child.
 - III. A blind or disabled adult child.
 - IV. State of Tennessee.
 - (II) No individual or entity other than those listed in Item (I) may be named as a beneficiary in a position superior to the State. A community spouse cannot name the institutionalized spouse as a remainder beneficiary of the annuity in a position superior to that of the State.
 - (III) As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term services and supports and home and community based services. The State must notify the issuer of the State's right as the preferred remainder beneficiary and the issuer must notify the State if there are any changes in the amount of income or principal being withdrawn.
 - (IV) An annuity may be amended to meet these criteria, so that the annuity purchase will not be treated as a transfer of assets for less than FMV.

- (V) The purchase of an annuity is subject to the transfer of assets provision unless it meets the requirements of 42 U.S.C. § 1396(c)(1)(F).
- (VI) The purchase of an annuity on or after February 8, 2006, by or on behalf of an annuitant who has applied for long term services and supports shall be treated as a transfer of assets for less than FMV unless the annuity is determined to be a countable resource, or, if it is excluded, it meets the criteria below. This only applies to annuities for which the individual is the annuitant (not the spouse).
- (VII) The annuity will not be treated as a transfer of assets if the annuity meets any of the following conditions:
 - I. The annuity is considered either:
 - A. An individual retirement annuity (Section 408(b) of the Internal Revenue Code of 1986 (IRC), 26 U.S.C. § 408(b)), or
 - B. A deemed Individual Retirement Account (IRA) under a qualified employer plan (Section 408(q) of the IRC 26 U.S.C. § 408(q)); or
 - II. The annuity is purchased with proceeds from one of the following:
 - A. A traditional IRA, Section 408a of the IRC (26 U.S.C. § 408(a));
 - B. Certain accounts or trusts which are treated as traditional IRAs, Section 408(c) of the IRC (26 U.S.C. § 408(c));
 - C. A simplified retirement account, Section 408(p) of the IRC (26 U.S.C. § 408(p));
 - D. A simplified employee pension, Section 408(k) of the IRC (26 U.S.C. § 408(k)); or
 - E. A Roth IRA, Section 408A of the IRC (26 U.S.C. § 408(a)); or
 - III. The annuity meets all of the following requirements:
 - A. The annuity is irrevocable;
 - B. The annuity is non-assignable;
 - C. The annuity is actuarially sound;
 - D. The annuity provides payments in approximately equal amounts, with no deferred or balloon payments; and
 - E. Periodic payments are provided to the annuitant.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

(1) Caretaker Relatives.

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

- (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Individual must be a parent or caretaker relative of a minor child and must agree to cooperate with State Child Support Enforcement to establish paternity and medical support, if applicable. Failure to cooperate or show good cause for not cooperating once eligible shall result in termination.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitation: Household income cannot exceed the monthly income levels as outlined in the State Plan. Note: The FFM uses these numbers to establish an equivalent FPL.
 - (f) Resource Limitation: None.
 - (g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
 - (h) Individuals in this category may also be eligible for Extended Medicaid as described in 42 CFR § 435.115 and Transitional Medicaid as described in 42 CFR § 435.112.
- (2) TennCare Pregnant Women.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Individual must be pregnant. Self-attestation of pregnancy is accepted unless the State has information that is not reasonably compatible with such attestation.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitation: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level. See Rule 1200-13-20-.06.
 - (f) Resource Limitation: None.
 - (g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
 - (h) Other:
 1. Eligibility is continuous through the last day of the month of the 60-day postpartum period as defined at 42 CFR § 435.4, regardless of income changes.
 2. An individual in this category is eligible for all medically necessary covered services, other than LTSS, because TennCare considers all medically necessary covered services to be pregnancy-related. A pregnant woman could be eligible for LTSS if she is determined to meet the criteria for an Institutional Medicaid category.
 3. Individuals in this category may also be eligible for Extended Medicaid as described in 42 CFR § 435.115 and Transitional Medicaid as described in 42 CFR § 435.112.
- (3) Presumptive Eligibility for Pregnant Women.
- (a) Definition: See Rule 1200-13-20-.02.

- (b) Technical Requirements: See Rule 1200-13-20-.04. Self-attestation of citizenship, residency and Social Security Number (SSN) are accepted at application for presumptive eligibility.
 - (c) Special Eligibility Requirements: Individual must be pregnant at the time of application. Self-attestation of pregnancy is accepted unless the State has information that is not reasonably compatible with such attestation.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitation: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level. See Rule 1200-13-20-.06.
 - (f) Resource Limitation: None.
 - (g) Effective Date of Eligibility: The date of determination by the Tennessee Department of Health or other qualified entity. The presumptive eligibility period ends the earlier of either the last day of the month following the month a presumptive eligibility determination was made or date of determination of a full Medicaid application, as defined in 42 CFR § 435.907, or as otherwise agreed to by the Single State Agency and CMS. Only one presumptive period of eligibility is allowed for each pregnancy.
- (4) Infants and Children under Age 19.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Individual must be younger than 19 years of age.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitations:
 1. Infants younger than age 1: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level.
 2. Children from age 1 to age 5: Household income cannot exceed one hundred forty two percent (142%) of the Federal Poverty Level.
 3. Children from age 6 to age 19: Household income cannot exceed one hundred thirty three percent (133%) of the Federal Poverty Level. See Rule 1200-13-20-.06.
 - (f) Resource Limitations: None.
 - (g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
 - (h) Individuals in this category may also be eligible for Extended Medicaid as described in 42 CFR § 435.115 and Transitional Medicaid as described in 42 CFR § 435.112.
- (5) Deemed Newborns.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04, except Deemed Newborns are not subject to citizenship rules. Newborns without an SSN must be enumerated by age one to remain eligible for another category, or before they can be approved in another category, whichever occurs first.

- (c) Special Eligibility Requirements: Newborns must be 12 months or younger. A baby born to a mother eligible for and receiving TennCare Medicaid shall be eligible for TennCare Medicaid for one year from the date of birth, as long as the newborn remains a resident of Tennessee during that time.
 - (d) Income Limitations: None.
 - (e) Resource Limitations: None.
 - (f) Effective Date of Eligibility: The child's date of birth, if mother was eligible for and receiving TennCare Medicaid at the time of birth.
- (6) Newborn Presumptive.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04. Self-attestation of residency is accepted at application for presumptive eligibility. SSN is not required for newborns to age 1.
 - (c) Special Eligibility Requirements: Newborns must be 12 months or younger.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitations: Household income cannot exceed one hundred ninety five percent (195%) of the Federal Poverty Level.
 - (f) Resource Limitations: None.
 - (g) Effective Date of Eligibility: The date of determination by the qualified entity. The presumptive eligibility period extends from the date of application through the end of the following month, or if a full Medicaid application is submitted before the end of the month following the presumptive application, eligibility continues until a determination is made on a complete Medicaid application.
- (7) Former Foster Care Children up to Age 26.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: The individual must be under age 26, have been in foster care provided by the State of Tennessee, and must have been receiving Medicaid in the foster care category at the time he aged out of custody in order to qualify for this category.
 - (d) Income Limitations: None.
 - (e) Resource Limitations: None.
 - (f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
- (8) Standard Child Uninsured.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Must be a Medicaid "Rollover" enrollee as defined in 1200-13-20-

.02, or currently enrolled in TennCare Standard, and does not have insurance or access to health insurance.

- (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitations: Household income must be at or below two hundred eleven percent (211%) of the Federal Poverty Level. See Rule 1200-13-20-.04.
 - (f) Resource Limitations: None.
 - (g) Effective Date of Eligibility: The day following the TennCare Medicaid coverage end date.
 - (h) Other: Includes uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below two hundred percent (200%) of the Federal Poverty Level, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. If a person loses eligibility in this category, he or she will not be able to re-enroll in it.
- (9) Standard Child Medically Eligible.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Must be an uninsured child under age 19 who is losing eligibility for Medicaid or being renewed as TennCare Standard, who does not have access to health insurance, and who has been determined to have a qualifying medical condition in accordance with these rules.
 - (d) Special Application Procedures:
 - 1. Must be a Medicaid "Rollover" enrollee as defined in 1200-13-20-.02, or currently enrolled in TennCare Standard.
 - 2. Applicants have three (3) options for proving medical eligibility:
 - (i) Option 1: Physician's attestation on the Medically Eligible (ME) Packet of specific qualifying conditions.
 - (ii) Option 2: A completed ME packet and medical records to support a qualifying medical condition with a signed release for medical records in the event additional medical records are needed.
 - (iii) Option 3: An existing Medically Eligible determination in Interchange.
 - 3. If a Medicaid enrollee under age nineteen (19) whose Medicaid eligibility is ending is determined to otherwise meet technical eligibility requirements for TennCare Standard, but is not eligible as uninsured because his income is above two hundred eleven percent (211%) of poverty, he will be sent a medically eligible packet.
 - 4. TennCare will send the enrollee a medical eligibility packet with an explanation regarding how to apply for TennCare Standard as a medically eligible person. The enrollee will have sixty (60) days from the date of the notice letter (inclusive of mail time) to submit his medical eligibility packet. If the individual is determined to qualify as medically eligible, coverage will be provided throughout the eligibility determination period and will continue with no break.
 - 5. The required medical eligibility application information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A medical

eligibility form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the sixtieth (60th) day will be denied with a notice of appeal rights.

- (e) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (f) Income Limitations: Household income must exceed two hundred eleven percent (211%) of the Federal Poverty Level. See Rule 1200-13-20-.06.
 - (g) Resource Limitations: None.
 - (h) Effective Date of Eligibility: The day following the TennCare Medicaid coverage end date.
- (10) CoverKids - CHIP Children under age 19.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Includes children under age 19 who do not have Health Insurance, as defined in rule 1200-13-20-.02.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitations: Must be over the applicable Medicaid limit and under two hundred fifty percent (250%) of the Federal Poverty Level. See Rule 1200-13-20-.06.
 - (f) Resource Limitations: None.
 - (g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
- (11) CoverKids Pregnant Women/Unborn Children.
- (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04. The pregnant woman's unborn child is presumed to be a U.S. citizen, regardless of the citizenship or immigration status of the mother. The mother is not required to provide proof of citizenship or immigration status.
 - (c) Special Eligibility Requirements: Includes pregnant women who do not have Health Insurance, as defined in Rule 1200-13-20-.02, or do not have maternity benefits or have exhausted maternity benefits.
 - (d) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
 - (e) Income Limitations: Must be ineligible for Medicaid and below two hundred fifty percent (250%) of the Federal Poverty Level. See Rule 1200-13-20-.06.
 - (f) Resource Limitations: None.
 - (g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
 - (h) Other: Eligibility for the pregnant woman is continuous through the 60 days postpartum period as defined at 42 CFR § 435.4. Eligibility for the newborn child continues twelve (12) months from the mother's effective date of eligibility.

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

- (a) Definition: Children in State foster care or in a subsidized adoptive home.
- (b) Eligibility for these categories is determined by the Tennessee Department of Children's Services.

(13) Transitional Medicaid.

- (a) Definition: See Rule 1200-13-20-.02.
- (b) Technical Requirements: See Rule 1200-13-20-.04.
- (c) Special Eligibility Requirements for Transitional Medicaid: Eligible individuals must have been eligible for and receiving benefits for at least three of the six months immediately preceding the month of ineligibility. Eligible individuals receive twelve months of Medicaid.
- (d) Special Eligibility Requirements for children: Transitional Medicaid benefits are provided to children who lose Child MAGI eligibility when the following conditions are met:
 - 1. The child's parent or caretaker relative was previously eligible in a MAGI category with income under the Caretaker Relative income standard for three of the previous six months but lost eligibility due to an increase in earnings; and
 - 2. The child was eligible and enrolled in a Child MAGI category for three of the six months immediately preceding the month the parent or caretaker relative lost eligibility.
- (e) Special Eligibility Requirements for Pregnant women: Transitional Medicaid benefits are provided to pregnant women who lose Pregnancy MAGI eligibility when all of the following conditions are met:
 - 1. The individual was eligible and enrolled in the Pregnancy MAGI category for three of the six months immediately preceding the month eligibility was lost;
 - 2. The woman's loss of eligibility is due to an increase in earnings; and
 - 3. The woman's household income was at or below the Caretaker Relative income standard for three of the six months immediately preceding the month eligibility was lost.
- (f) Special Eligibility Requirements for Caretaker Relatives: Transitional Medicaid benefits are provided to parents and caretaker relatives who lose Caretaker Relative MAGI eligibility when all of the following conditions are met:
 - 1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three of the six months immediately preceding the month eligibility was lost;
 - 2. Loss of eligibility was due to an increase in earnings; and
 - 3. The parent or caretaker relative must continue to have a dependent child in the home in order to receive Transitional Medicaid.
- (g) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
- (h) Income Limitations: See Rule 1200-13-20-.06.

(14) Extended Medicaid.

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

- (b) Technical Requirements: See Rule 1200-13-20-.04.
- (c) Special Eligibility Requirements: Eligible individuals must have been eligible for and receiving benefits for at least three out of six months immediately preceding the month of ineligibility. Eligible individuals receive twelve months of Medicaid.
- (d) Special Eligibility Requirements for children: Extended Medicaid benefits are provided to children who lose Child MAGI eligibility when the following conditions are met:
 1. The child's parent or caretaker relative was previously eligible in a MAGI category with income under the Caretaker Relative income standard for three of the previous six months but lost eligibility due to an increase in spousal support; and
 2. The child was eligible and enrolled in a Child MAGI category for three of the six months immediately preceding the month the parent or caretaker relative lost eligibility.
- (e) Special Eligibility Requirements for Pregnant women: Extended Medicaid benefits are provided to pregnant women who lose Pregnancy MAGI eligibility when the following conditions are met:
 1. The individual was eligible and enrolled in the Pregnancy MAGI category for three of the six months immediately preceding the month eligibility was lost;
 2. The woman's loss of eligibility is due to an increase in spousal support; and
 3. The woman's household income was at or below the Caretaker Relative income standard for three of the six months immediately preceding the month eligibility was lost.
- (f) Special Eligibility Requirements for Caretaker Relatives: Extended Medicaid benefits are provided to parents and caretaker relatives who lose Caretaker Relative MAGI eligibility when the following conditions are met:
 1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three of the six months immediately preceding the month eligibility was lost;
 2. Loss of eligibility was due to an increase in spousal support; and
 3. The parent or caretaker relative must continue to have a dependent child in the home in order to receive Transitional Medicaid.
- (g) Household size is based upon the MAGI household composition rule at 1200-13-20-.06.
- (h) Income Limitations: See Rule 1200-13-20-.06.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.08 Aged, Blind or Disabled Categories.

- (1) Supplementary Security Income (SSI) Cash recipient.
 - (a) Aged, blind or disabled individuals who are determined eligible for SSI payments by the SSA. If individuals are determined eligible for SSI payments in Tennessee by the SSA, they are eligible for TennCare Medicaid. Once SSI payments in Tennessee stop, the individual becomes an inactive SSI enrollee who must be reviewed for eligibility in all other categories.
 - (b) Effective date of eligibility: Date of SSI eligibility as determined by SSA.

- (2) Disabled Adult Child
 - (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: Disabled adult children who lose SSI eligibility after July 1, 1987 because of the receipt of or an increase in benefits for DAC payments under Title II of the Social Security Act will remain eligible for Medicaid if the initial entitlement under Title II above and/or cost-of-living increases, whichever caused the ineligibility for SSI, were disregarded.
 - (d) Income Limitations: SSI Federal Benefit Rate.
 - (e) Resource Limitations: \$2,000 for an individual, \$3,000 for a couple.
 - (f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
- (3) Pickle Passalong.
 - (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: TennCare Medicaid benefits are available to individuals who would be eligible for SSI payments if increases in their Social Security benefits due to cost-of-living adjustments were disregarded. Individuals who meet all other non-financial and financial eligibility requirements remain eligible for TennCare Medicaid if they:
 1. Were eligible for and received both Social Security and SSI benefits in the same month since April 1977. The SSI recipient who receives Social Security retroactive benefits is considered for TennCare Medicaid purposes to have received SSI and Social Security benefits in the same month, if Social Security eligibility overlaps a month the individual also received SSI benefits;
 2. Lost eligibility for SSI since April 1977;
 3. Currently receive Social Security benefits authorized under Title II of the Social Security Act; and
 4. Have countable income equal to or less than the current SSI Federal Benefit Rate after all applicable cost-of-living adjustments have been deducted.
 - (d) Income Limitations: SSI Federal Benefit Rate.
 - (e) Resource Limitations: \$2,000 for an individual, \$3,000 for a couple.
 - (f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
- (4) Widow/Widower.
 - (a) Definition: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements. A disabled widow/widower is eligible for TennCare Medicaid for any

month in which he is entitled to a Social Security Widow/Widower benefit, but is not eligible for SSI, if he:

- (i) Was eligible for SSI based on his own disability;
 - (ii) Was entitled to the Social Security Widow/Widower benefit any time after the age of 50;
 - (iii) Lost SSI eligibility in the first month that the Social Security Widow/Widower benefit was paid;
 - (iv) Has been continuously entitled to the Social Security Widow/Widower benefit from the month that the SSI was authorized;
 - (v) Would be eligible for SSI if the Widow/Widower entitlement and all subsequent COLAs were disregarded;
 - (vi) Is not entitled to Medicare Part A; and
 - (vii) Is at least age 50 and up to age 65.
- (d) Income Limitations: SSI Federal Benefit Rate.
- (e) Resource Limitations: \$2,000 for an individual, \$3,000 for a couple.
- (f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
- (5) Institutional Medicaid.
- (a) Definitions: See Rule 1200-13-20-.02.
 - (b) Technical Requirements: See Rule 1200-13-20-.04.
 - (c) Special Eligibility Requirements: To gain eligibility in this category, applicants must either be determined to meet the medical (level of care) eligibility criteria for CHOICES to receive payments for long term services and supports through the CHOICES Group 1 or Group 2 benefits package or be continuously confined in an institution for 30 consecutive days. Receipt of hospice services in a nursing facility for any length of time meets the 30-day continuous confinement requirement.
 - (d) Household size is based upon the Aged, Blind, and Disabled household composition rules at 1200-13-20-.06.
 - (e) Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual.
 - (f) Resource Limitations: Resources shall not exceed \$2,000 for an individual or \$3,000 for a couple.
 - (g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.
 - (h) Special Asset Rules:
 - 1. Asset Disregards for Qualified Long-Term Care Insurance Policies.
 - (i) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare. TennCare shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the

time of TennCare application.

- (ii) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.
 - (iii) Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery. When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above, even if a qualified long term care policy's benefits were not completely exhausted.
2. Entrance Fees: Any contractual provision requiring the resident to deposit entrance fees must take into account the required allocation of resources or income to the community spouse before determining the resident's cost of care. In addition the entrance fee paid to the Continuing Care Retirement Community (CCRC) or life care community is treated as a resource to an individual for purposes of determining Medicaid eligibility. The following three (3) conditions must be met in order for the entrance fee to be considered an available resource:
- (i) Any portion of the entrance fee is refunded or used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;
 - (ii) The entrance fee, or any portion thereof, is refundable under the terms of the contract when the individual dies or terminates the contract and leaves the CCRC or life care community, whether or not any amount is actually refunded; and
 - (iii) The entrance fee does not confer an ownership interest in the community.
3. Funds used to purchase a loan, mortgage or promissory note after February 8, 2006 must be treated as a transfer of assets unless it has a repayment term that is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral or balloon payment, and prohibits cancellation of the balance upon the death of the lender. If an individual purchases a home from a nursing home applicant and the purchase agreement does not meet the criteria of this part, the value of the home will be the outstanding balance due as of the date of the application for Medicaid.
4. A life estate interest purchased by a nursing home applicant in another individual's home shall be treated as a transfer of assets unless the nursing home applicant resides in the home for a period of at least one (1) year after the date of the purchase.
- (i) Transfer of Assets – An applicant for Institutional Medicaid shall not transfer assets for less than fair market value during the sixty (60) months prior to the date of application. If an individual is found to have transferred an asset for less than fair market value, he will be ineligible for payments for Long-Term Services and Supports.
1. An individual shall not receive a period of ineligibility to the extent that:
- (i) The asset transferred was a home and title to the home was transferred to:
 - (I) The spouse of the individual;
 - (II) A child of the individual who is younger than age 21 or blind and permanently and totally disabled;

- (III) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or
 - (IV) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual.
- (ii) The assets:
 - (I) Were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;
 - (II) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;
 - (III) Were transferred to, or to a trust established solely for the benefit of, the individual's blind or permanently disabled child; or
 - (IV) Were transferred to a trust established pursuant to 42 U.S.C. § 1396p(d)(4).
 - (iii) A satisfactory showing is made that:
 - (I) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration;
 - (II) The assets were transferred exclusively for a purpose other than to qualify for medical assistance;
 - (III) All assets transferred for less than fair market value have been returned to the individual; or
 - (IV) The denial of eligibility for Long-Term Services and Supports would work an undue hardship on the individual as defined in this rule.
2. The transfers indicated below, if occurring on or after February 8, 2006, may be considered a transfer of assets for less than fair market value with respect to an individual applying for Medicaid based on institutionalization:
- (i) If the transfer of assets occurs within sixty (60) months of application for institutional care.
 - (ii) If the institutionalized individual, his spouse, or any person, court or administrative body with authority to act on behalf of, or at the direction or request of, the individual or his spouse, establishes a trust or similar device, which includes the individual's assets and cannot be used by or for the individual's benefit, if it occurred within sixty (60) months of application for institutional care.
 - (iii) If an asset is held jointly by the institutionalized individual with another person and the individual or other owner reduces or eliminates the institutionalized individual's ownership or control of the asset, if it occurred within sixty (60) months of application for institutional care.
- (j) Penalty for transfer of assets.
 - 1. The institutionalized individual may be subject to penalty if the transfer was completed by the individual; the individual's spouse; a person (including a court) or administrative body with legal authority to act in place of, or on behalf of, or at the direction or request of the institutionalized

individual or his spouse.

2. Assets include all income and resources, including the home, unless transferred as indicated in subparagraph (i) above, of the institutionalized individual and his spouse, (including income and/or resources the individual is entitled to, but does not receive because of any action by the individual or his spouse or a person (including a court) or administrative body with legal authority to represent the individual, his spouse, or who acts at the direction or request of the individual and his spouse).
 3. Penalty period: The period of ineligibility for payments for long-term services and supports in the CHOICES Program imposed for transfers of assets within sixty (60) months prior to application for long term care nursing services.
 - (i) Determined by dividing the uncompensated value of the transferred asset by the average daily nursing home private pay rate. In determining the penalty for a transfer a State may not round down or disregard any fractional period of ineligibility. There is no limit on the maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist.
 - (ii) The penalty period for individuals receiving nursing home care begins the month the individual becomes eligible for LTSS through the CHOICES Program or the month of the transfer, whichever is later. The penalty period for HCBS begins the date of application or the date of the transfer for individuals already receiving HCBS. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a notice of penalty. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.
 - (iii) Applicants for, or enrollees in, nursing home coverage can still remain eligible in an Institutional Medicaid category while payments for LTSS are withheld. Applicants for, or enrollees in, home and community-based services cannot be eligible for an Institutional Medicaid category while subject to the period of ineligibility.
 - (iv) Penalty periods for more than one transferred asset will run consecutively, not concurrently. Any uncompensated value from multiple transfers is added to the initial uncompensated value if penalty periods overlap to determine the consecutive penalty period.
- (k) Undue hardship.
1. Undue Hardship shall exist only when:
 - (i) An application of a transfer of assets provision would deprive the individual of medical care, such that the individual's health or life would be endangered, or of food, clothing, shelter, or other necessities of life;
 - (ii) The institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations, and
 - (iii) The necessary care is not available from any other source.
 2. The individual, the individual's responsible party, or the facility in which an institutionalized individual resides may file an undue hardship claim on behalf of the applicant/recipient. TennCare will determine whether hardship exists and notify the applicant/recipient within thirty (30) days of filing.
 3. If undue hardship is determined not to exist, the denial of undue hardship may be appealed

within forty (40) days.

- (I) Patient Liability - Individuals determined eligible for Institutional Medicaid are required to contribute to the cost of their care as a resident in a nursing facility or as a Home and Community Based Services (HCBS) recipient.
1. Patient liability is determined by allowing the following deductions from the individual's gross income:
 - (i) A Personal Needs Allowance (PNA) for clothing and other personal needs while receiving Institutional Medicaid. Apply the appropriate PNA based on the type of long term services and supports the individual receives, in accordance with the following:
 - (I) Nursing Facility. \$50 PNA from the gross income of an individual in nursing facility.
 - (II) HCBS, PACE and Self-Determination ID Waivers. PNA is 300% of the SSI FBR.
 - (III) Statewide ID and Comprehensive Aggregate Cap ID Waivers. PNA is 200% of the SSI FBR.
 - (ii) An allowance equivalent to the monthly fee for maintenance of a QIT, if applicable.
 - (iii) A CSIMA for institutionalized individuals with a spouse residing in the community.
 - (iv) A DIMA for institutionalized individuals with a dependent residing in the community.
 - (v) Health insurance premiums, coinsurance and deductibles.
 - (vi) Expenses for medical services as defined at 42 CFR §§ 435.725(c)(4) and 726(c)(4).
 2. Community Spouse Income Maintenance Allowance (CSIMA) – When determining an institutionalized individual's patient liability, an allowance is deducted from his or her income for the needs of the community spouse. The CSIMA is allowed unless specifically refused by the institutionalized spouse. Funds must actually be transferred to the community spouse in order to be deducted.
 - (i) CSIMA is allowed under the following conditions:
 - (I) CSIMA is not allowed if both spouses are receiving Institutional Medicaid, unless one spouse is receiving HCBS.
 - (II) If the community spouse applies for TennCare Medicaid, the CSIMA will be counted as unearned income at the time of application.
 - (III) A community spouse receiving need-based assistance does not have to accept the total or any of the income allocation if it will result in the termination or decrease of those benefits.
 - (IV) If a couple is married but living separately, and considers themselves to be separated, the CSIMA may be allowed if both individuals agree to the allocation and the community spouse is not institutionalized.
 - (V) If the community spouse lives out of State, the CSIMA is allowed if the community spouse can be located and the couple is still married.
 - (ii) CSIMA Terms and Standards:

- (I) Standard Maintenance Amount (SMA): The minimum monthly amount of income, as determined by CMS, that the Community Spouse must receive to meet basic needs. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.
 - (II) Maximum Maintenance Needs Allowance (MMNA): The maximum monthly amount of income, as determined by CMS, that the Community Spouse can receive as a CSIMA. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.
 - (III) Standard Utility Amount (SUA): The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, then it is considered to cover all utilities, including garbage, water, lighting, etc. The SUA is subject to annual change by the Tennessee Department of Human Services.
 - (IV) Standard Housing Allowance (SHA): The SHA is used to determine whether the community spouse requires an Excess Shelter Allowance. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.
- (iii) CSIMA Calculation: The CSIMA is calculated using three steps:
- (I) Determine Excess Shelter Allowance (ESA).
 - I. An ESA is allowed when the total shelter costs for rent, mortgage, taxes and insurance, maintenance charges and utility costs exceed the SHA. The SHA is 30% of the Standard Maintenance Amount.
 - II. The SUA is used when the community spouse is responsible for heating or cooling costs. If the SUA is used then it is considered to cover all utilities (no additional allowance for garbage, telephone, etc.). When there is no or reduced cost to the community spouse because the cost of a particular utility is paid by a third party (in cash or in-kind), reduce the amount of the SUA by the third party payment.
 - III. To determine the ESA, add rent, mortgages, taxes, insurance, etc., to the SUA, then subtract the SHA.
 - (II) Determine Community Spouse Net Income. Defined as income over which the Community Spouse has control and which is actually available to him. Child support payments and other types of court-ordered payments made by the Community Spouse are not considered income available to the Community Spouse.
 - (III) Calculate CSIMA: The CSIMA is calculated by adding the SMA and the ESA, and then subtracting the Community Spouse's net income.
3. Dependent Income Maintenance Allowance (DIMA): When determining patient liability, an allowance is deducted from the individual's income for the needs of his dependents.
- (i) Dependent relatives include all persons who can be or are being claimed as tax dependents.
 - (ii) A DIMA is not allowed for any dependent receiving HCBS or who is institutionalized.
 - (iii) Pursuant to the Medicare Catastrophic Coverage Act, a dependent does not have the option of declining all or a portion of the income allocation for any reason, even if needs-based benefits may be decreased or lost because of the allocation.

- (iv) The total of both the CSIMA and DIMA combined cannot exceed the MMNA.
 - (v) The MMNA for each additional dependent family member is equal to one-third of the difference between the SMA and the dependent's gross income.
 - (vi) DIMA Calculation: The dependent allocation(s) equals the SMA for the community spouse minus the dependent's own gross countable income divided by 3.
4. Item D Expenses: Expenses for medical or remedial care not subject to third party payment as defined at 42 CFR §§ 435.725(c)(4), .726(c)(4) and .832, and outlined in the State Plan are allowable deductions. Criteria for Deduction of an Item D Expense:
- (i) The expense must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, the client's spouse or family or medical trust fund, Medicare, etc.
 - (ii) The expense may be unpaid or paid by the client during the month(s) of eligibility determination or paid by a member of the client's family and reimbursement is expected by the family member.
 - (iii) The expense must not have been allowed previously as an allowed necessary item.
 - (iv) If payment for the item is outstanding, it must be considered collectible by the party who provided the medical service and one for which the client is legally liable.
 - (v) Medical expenses incurred during TennCare Medicaid ineligibility do not impact whether the bill is an allowable medical expense.
 - (vi) Deductions will be allowed in accordance with 42 CFR §§ 435.725(c)(4), .726(c)(4), and .832, and the State Plan.

(m) Resource Assessment and CSRMA.

1. Resource Assessment: When determining eligibility for a married institutionalized applicant, a calculated amount of the couple's assets is allocated to the community spouse in order to be used for his/her own needs. The resource assessment is a snapshot of all countable assets owned by the couple at the time the individual enters the nursing facility but conducted when the individual applies or when an assessment is requested prior to application. All of the countable resources owned individually or jointly by both spouses are counted; resources excluded under the ABD resource rules are not counted in the resource assessment.
 - (i) Only one resource assessment will be completed for a married couple.
 - (ii) Under no circumstances can a resource assessment be completed prior to the date of admission to a long term care facility or enrollment in an HCBS waiver.
 - (iii) An assessment remains in effect until a HCFA application is filed, regardless of any interruptions in long-term care. If a resource assessment is completed and the individual applies for TennCare Medicaid, but is found ineligible, the original resource assessment is still valid if the individual applies again in the future.
2. Community Spouse Resource Maintenance Allowance: The CSRMA is based on the spouses' combined countable resources documented in the Resource Assessment. The amount of the CSMRA is the greater of:
 - (i) One-half (1/2) of the total countable resources, but not less than the Minimum Resource

Standard or greater than the Maximum Resource Standard (released in the SSI and Spousal Impoverishment Standards and subject to change annually);

- (ii) The court-ordered amount; or
 - (iii) The amount determined by a HCFA Eligibility Appeals Administrative Judge due to a hardship situation (extreme financial duress).
3. When an application is filed by or on behalf of the spouse seeking LTSS, the CSRMA amount determined in the resource assessment is the amount allocated to the community spouse. This amount is deducted from the combined resources of both spouses as of the first day of the first month for which assistance is requested. None of the community spouse's share of the resources is considered available to the individual seeking eligibility when determining his or her TennCare Medicaid eligibility.
4. Refusal of CSRMA. - A community spouse who receives needs-based assistance may accept or decline all, some or none of the CSRMA if the allocation would cause the loss of or decrease in those program benefits. If the community spouse accepts only a portion of the CSRMA, the unclaimed portion of the CSRMA is counted as part of the institutionalized spouse's resources.
5. Resource Transfer as a Result of Assessment.
- (i) CSRMA "Grace Period" - Following a resource assessment and initial approval of eligibility, resources must be transferred within twelve (12) months of the approval. Both spouses must agree to the transfer in order to use the institutionalized spouse's share in determining his or her eligibility. The transfer may require conveyance of resources from the institutionalized individual to the community spouse, or vice versa.
 - (ii) Transfer Refusal - When the community spouse refuses to transfer resources to the institutionalized individual, the institutionalized spouse may still be eligible if on appeal the State finds that undue hardship circumstances exist.
 - (I) If the community spouse has available assets over the CSRMA he or she is legally obligated to provide support.
 - (II) Hardship cannot be determined to exist unless assets have been reallocated as the result of an appeal decision or a court order.
 - (iii) CSRMA Appeals.
 - (I) When the Individual and/or Spouse Has Appeal Rights - Appeal rights are considered only after a HCFA application has been filed and either spouse alleges that the assessment or eligibility determination decision is not correct. An assessment completed exclusive of a filed application cannot be appealed. Revisions to the spousal allowance of resources can be made by an HCFA Eligibility Appeals Administrative Judge or by court order.
 - (II) CSRMA Revisions - The amount of the CSRMA may only be revised by an HCFA Eligibility Appeals Administrative Judge or by court order, and only if additional verification/documentation is provided. The CSRMA may only be revised when:
 - I. The initial assessment was alleged to be incorrect and the HCFA Eligibility Appeals Administrative Judge confirms the allegations.
 - II. The community spouse's income, including the CSIMA, is inadequate to meet the basic standard maintenance amount.

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

- I. When Additional Resources May be Allocated to Community Spouse: An HCFA Eligibility Appeals Administrative Judge may determine a larger CSRMA if necessary to offset a CSIMA that is below the required SMA. In the event that the institutionalized spouse does not have enough income to provide the community spouse with the SMA, and the couple has additional resources above the community spouse's protected amount (CSRMA), some or all of the institutionalized individual's resources can be allocated to the community spouse.
- II. The Deficit Reduction Act (DRA) of 2005 requires all States to allocate the maximum amount of available income of the institutionalized spouse to the community spouse before granting an increase in the CSRMA. This is referred to as the "income-first" method.
- III. Procedure: HCFA uses the Single Fixed Annuity model to address appeals when there is insufficient income to provide the community spouse with the minimum required CSIMA and the couple has additional resources. A single fixed annuity can turn a portion of an individual's savings into income payments made for the rest of the individual's life. The procedure for establishing a Single Fixed Annuity is listed below.
 - A. Additional resources may be allocated to the community spouse through the HCFA eligibility appeals process to make up any shortfall between the amount of income allocated from the institutional spouse to the community spouse and the SMA, if determined appropriate.
 - B. The amount of additional resources that are necessary to cover the income shortfall shall be determined in reference to the purchase of a Single Premium Annuity as follows:
 - (A) By calculating the shortfall between the amount of income allocated and the SMA, and then determining the amount of additional resources that must be invested in a single premium annuity in order to generate the income necessary to cover the shortfall.
 - (B) The amount of resources needed to cover the shortfall shall be determined in reference to an annuity calculator as adopted by the HCFA.
 - (C) The additional resource allocation to the community spouse does not require the actual purchase of a Single Premium Annuity that is used for purposes of calculating the amount of the additional resource allocation.
 - (D) The amount of the community spouse's protected resources shall be excluded from this calculation.
 - (E) If a single premium annuity is actually purchased pursuant to these rules, the annuity must comply with all other relevant requirements of State and federal law.
 - (F) The amount of additional resources that are necessary to cover the shortfall in the SMA shall not be determined in reference to any investment which contemplates the return of the entire

principal at maturity.

(iv) Transfer of Assets for Less than Fair Market Value.

- (I) A transfer of assets for less than fair market value is not considered to have occurred when resources are transferred from the institutionalized individual to the community spouse or vice versa in accordance with a completed resource assessment.
- (II) Should the spouse who received the allocation in accordance with the resource assessment then transfer the resource to someone else for less than fair market value, the transfer will be treated as a transfer of assets by the institutionalized individual.
- (III) Transfer of assets for less than fair market value is considered part of the application process whether or not a resource assessment has been requested previously or is requested at application. Transfer of assets is not considered if a resource assessment only (no TennCare Medicaid application filed concurrently) is requested.

(6) Medicare Savings Programs.

(a) QMB.

- 1. Definition: See Rule 1200-13-20-.02.
- 2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QMB is eligible for TennCare Buy-in of their Medicare premiums, and payment of Medicare coinsurance and deductibles.
- 3. Technical Requirements: See Rule 1200-13-20-.04.
- 4. Household size is based upon the ABD household composition rules at 1200-13-20-.06.
- 5. Income Limitations: Below 100% of the FPL.
- 6. Resource Limitations: Limits for an individual and couple as determined by SSA.
- 7. Effective Date: First day of the month following the month in which the application is approved.

(b) SLMB.

- 1. Definition: See Rule 1200-13-20-.02.
- 2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for SLMB is eligible for TennCare Buy-in of their Medicare Part B premiums.
- 3. Technical Requirements: See Rule 1200-13-20-.04.
- 4. Household size is based upon the ABD household composition rules at 1200-13-20-.06.
- 5. Income Limitations: Over 100% but less than 120% of the FPL.
- 6. Resource Limitations: Limits for an individual and couple as determined by SSA.
- 7. Effective Date: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(c) Q11.

1. Definition: See Rule 1200-13-20-.02.
2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for Q11 is eligible for TennCare Buy-in of their Medicare Part B premiums, pursuant to State allocation of federal funds. Individuals may not be receiving TennCare Medicaid.
3. Technical Requirements: See Rule 1200-13-20-.04.
4. Household size is based upon the ABD household composition rules at 1200-13-20-.06.
5. Income Limitations: Over 120% but less than 135% of FPL.
6. Resource Limitations: Limits for an individual and couple as determined by the SSA.
7. Effective Date: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(d) QDWI.

1. Definition: See Rule 1200-13-20-.02.
2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QDWI is eligible for TennCare Buy-in of their Medicare Part A premiums, but not for Part B premiums.
3. Technical Requirements: See Rule 1200-13-20-.04.
4. Special Eligibility Requirements: Individuals must be under age 65, have a disabling impairment as determined by the SSA, and be eligible to enroll in Medicare Part A but no longer entitled to free Medicare Part A due to substantial gainful activity.
5. Household size is based upon the ABD household composition rules at 1200-13-20-.06.
6. Income Limitations: 200% of FPL.
7. Resource Limitations: Resources not exceeding twice the maximum for SSI.
8. Effective Date: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(7) Other.

(a) Medically Needy Children and Pregnant Women.

1. Definition: See Rule 1200-13-20-.02.
2. Technical Requirements: See Rule 1200-13-20-.04.
3. Special Eligibility Requirements: Applicants for the Medically Needy Pregnant Woman category must be pregnant at the time of application. Applicants for the Child Medically Needy category must be under age 21.
4. Household size is based upon the AFDC-Related household composition information set out in rule .06.

5. Income Limitations: Household income must be less than or equal to the MNIS, based on household size. When household income exceeds the MNIS, based on household size, the individual must meet a spend-down obligation as outlined in the State Plan. See Rule 1200-13-20-.06.
6. Resource Limitations: Medically Needy applicants are permitted to retain resources not to exceed \$2,000 for an individual, \$3,000 for two individuals and an additional \$100 is added per additional person. See 1200-13-20-.06.
7. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05 or the date all eligibility requirements are met, whichever is later.
8. Other: Pregnant women enrolled in the Medically Needy program shall receive continuous coverage through two months postpartum, regardless of income changes.

(b) Breast and Cervical Cancer Category of Eligibility.

1. Definition: See Rule 1200-13-20-.02.
2. Technical Requirements: See Rule 1200-13-20-.04.
3. Special Eligibility Requirements:
 - (i) Individuals must be younger than age 65 and must lack health insurance that will cover treatment for breast and/or cervical cancer. Once third party coverage of cancer has been exhausted, applicant will be considered to no longer have health insurance.
 - (ii) Individuals must first be screened and approved by the Department of Health's BCCP.
 - (iii) Individuals must be actively undergoing treatment for breast or cervical cancer. A Treatment Plan Form signed by the applicant's physician must be submitted to TennCare. Individuals who are determined to require only routine monitoring services for a precancerous breast or cervical condition are not considered to need treatment for purposes of this section. Surveillance after treatment of cancer (breast or cervical) will not qualify as treatment for purposes of this section.
4. Income Limitations: Income cannot exceed two hundred fifty percent (250%) of the FPL, as determined by the Department of Health through its BCCP.
5. Resource Limitations: None.
6. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(c) Presumptive Breast or Cervical Cancer.

1. Definition: See Rule 1200-13-20-.02.
2. Technical Requirements: See Rule 1200-13-20-.04.
3. Special Eligibility Requirements:
 - (i) Individual must be determined to be presumptively eligible by the Department of Health.
 - (ii) Individual must be younger than age 65 and must lack access to health insurance that will cover treatment for breast and/or cervical cancer.

- (iii) The presumptive eligibility period will last either until the end of the month following the month of application or determination of a full Medicaid application, as defined in 42 U.S.C. § 1396r-1b.
 - 4. Income Limitations: Income cannot exceed two hundred fifty percent (250%) of the FPL, as determined by the Department of Health through its BCCP program.
 - 5. Resource Limitations: None.
 - 6. Effective Date of Eligibility: The date eligibility is determined by the Tennessee Department of Health.
- (d) Payment for Emergency Medical Services.
- 1. Definition: See Rule 1200-13-20-.02.
 - 2. Technical Requirements: See Rule 1200-13-20-.04. Individuals must meet eligibility requirements for a Medicaid category except for citizenship and enumeration.
 - 3. Special Eligibility Requirements: Individuals who meet all eligibility criteria except citizenship and immigration status for the following TennCare categories of eligibility:
 - (i) Caretaker Relative;
 - (ii) Infants and Children Under Age 19;
 - (iii) Pregnant Woman; or
 - (iv) Child or Qualified Pregnant Woman Medically Needy.
 - 4. Individuals in one of the above categories may qualify for payment for emergency medical services in which the individual has a medical condition, including labor and delivery, manifested by acute symptoms of sufficient severity which, if not attended to immediately, could reasonably be expected to result in:
 - (i) Placing the patient's health in serious jeopardy;
 - (ii) Severe impairment to bodily functions; or
 - (iii) Serious dysfunction of any bodily organ or part.
 - 5. Household size is based upon the appropriate TennCare category for which the enrollee is seeking coverage.
 - 6. Income Limitations: Must meet financial criteria of one of the respective TennCare categories (Caretaker Relative, Infants and Children Under Age 19, TennCare Pregnant Woman, or Child or Qualified Pregnant Woman Medically Needy).
 - 7. Resource Limitations: If an individual would be otherwise eligible for a Medically Needy category except for citizenship or immigration status, then the individual's resource limits are identical to those found in rule .06, AFDC-Related Financial Determinations. If an individual would be otherwise eligible for a MAGI category except for citizenship or immigration status, then the individual's resources are not considered.
 - 8. Effective Date of Eligibility: Eligibility will not begin prior to the date of admission, nor will coverage begin prior to the date of application, and will be limited to the length of time required to stabilize the emergent episode, as defined at 42 CFR § 440.255. Only the services involved

in the emergency itself will be reimbursed and coverage is only provided for the single episode of care.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

1200-13-20-.09 Redetermination and Termination.

- (1) Redetermination of eligibility for CoverKids, TennCare Medicaid's Core Medicaid Population, and TennCare Standard.
 - (a) Redetermination or renewal is the process of verifying whether an enrollee continues to meet the eligibility requirements of a particular HCFA program.
 1. A TennCare Medicaid, TennCare Standard or CoverKids enrollee must have eligibility redetermined once every 12 months, and no more frequently than once every 12 months, absent a waiver from CMS.
 2. Redetermination dates are set 12 months from the date the individual is determined eligible for TennCare Medicaid, TennCare Standard or CoverKids, or as otherwise agreed between the Single State Agency and CMS.
 - (b) Enrollees eligible for TennCare Medicaid as a result of being eligible for SSI benefits shall follow the Redetermination requirements of the SSA. Once SSI benefits are terminated, these enrollees will be reviewed by the State for eligibility in all other categories prior to termination.
 - (c) An enrollee's TennCare Medicaid, TennCare Standard or CoverKids eligibility shall be redetermined as required by the appropriate category of medical assistance as described in this chapter, unless otherwise agreed to by the Single State Agency and CMS. Prior to the termination of TennCare Medicaid, TennCare Standard or CoverKids eligibility, eligibility will be redetermined in accordance with the following process:
 1. HCFA will redetermine eligibility prior to the expiration of the enrollee's current eligibility period.
 2. HCFA will issue a renewal packet to redetermine eligibility. TennCare Medicaid, TennCare Standard or CoverKids enrollees will be given forty (40) days, inclusive of mail time, from the date the notice is mailed to return the completed renewal packet to HCFA. The mail date will be the date on the notice. The enrollee may provide information by mail, fax or in-person.
 3. Enrollees with a physical health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the renewal form. Enrollees with limited English proficiency will have the opportunity to request translation assistance for responding to the renewal form.
 4. HCFA will use the individual's responses in the renewal packet to complete redetermination. HCFA will request additional verification, as needed, to complete redetermination. The request for additional information or verification will provide the enrollee with twenty (20) days, inclusive of mail time, to submit the requested information.
 5. If HCFA is able to renew eligibility in a TennCare Medicaid, TennCare Standard or CoverKids category based on information provided in the renewal packet, in addition to information known to HCFA and requested verifications, the agency will notify the enrollee and enroll him in the new appropriate category.
 6. Enrollees who respond to the renewal form within the forty (40) day period shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while HCFA reviews their eligibility for open Medicaid categories and

CoverKids. If HCFA determines that the enrollee is eligible for a TennCare Medicaid, TennCare Standard or CoverKids category, the agency will notify the individual as follows:

- (i) If HCFA determines that the enrollee is eligible for an open TennCare Medicaid category, the agency will notify the enrollee and he will be enrolled in the appropriate category. The previous category will be closed with no further notice to the enrollee.
 - (ii) If HCFA determines that the enrollee is eligible for a TennCare Standard category, the agency will notify the enrollee and he will be enrolled in the appropriate category. Notification of enrollment into TennCare Standard will include notification of the denial of TennCare Medicaid eligibility.
 - (iii) If HCFA determines that the enrollee is eligible for CoverKids, the agency will notify the enrollee and he will be enrolled into the CoverKids program. Notification of enrollment into CoverKids will include the denial of TennCare Medicaid eligibility.
7. If an enrollee provides some but not all of the necessary information to HCFA to determine his eligibility for open Medicaid categories or CoverKids during the forty (40) day period following the mailing of the renewal packet, HCFA will request additional information or verification. The request for additional information or verification will provide the enrollee with twenty (20) days, inclusive of mail time, to submit the requested information.
 8. Enrollees who do not respond to the renewal packet within forty (40) days, or enrollees who do not respond to a request for additional information or verification within twenty (20) days from the request for additional information or verification, will be sent a notice of termination informing the enrollee that coverage will be terminated 20 days from the date of the termination notice.
 9. If HCFA makes a determination that the enrollee is not eligible for any open Medicaid categories, TennCare Standard or CoverKids, the enrollee will be sent a notice of termination informing the enrollee that coverage will be terminated 20 days from the date of the termination notice.
 10. Enrollees who respond to the additional information or verification request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare Medicaid, TennCare Standard or CoverKids while HCFA reviews their eligibility.
 11. Individuals may provide the renewal packet, or additional information and verifications specified in the request for additional information and verification notice, up to 90 days after termination of eligibility. Renewal packets or additional information and verification received during the 90 day reconsideration period will be processed as required by 42 CFR § 435.916. Individuals terminated for failure to respond and subsequently determined eligible during the 90 day reconsideration period will have eligibility reinstated as of the date of termination.
 12. Renewal packets returned after 90 days will be considered new applications and processed in accordance with 1200-13-20-.05.
- (d) A woman who has been determined eligible for TennCare Medicaid under the rules for BCCP shall annually recertify her eligibility in terms of continuation of active treatment, her address, and access to health insurance. If she is found to no longer be eligible through this review, the enrollee will be reviewed using the redetermination process set forth in this paragraph.
- (2) Termination of TennCare Medicaid, TennCare Standard and CoverKids eligibility.
 - (a) HCFA will send termination notices to all enrollees being terminated pursuant to State and federal law who are not determined to be eligible for open Medicaid or TennCare Standard categories, or

CoverKids.

- (b) Termination notices will be sent twenty (20) days in advance of the date the coverage will be terminated. Termination notices will be sent two (2) days in advance of the date coverage will be prospectively terminated when an enrollee requests termination. Termination notices will be sent to the HCFA address of record.
- (c) Termination notices will provide enrollees forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by HCFA in accordance with chapter 1200-13-19.
- (d) Enrollees with a physical health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with limited English proficiency will have the opportunity to request translation assistance for their appeal.

Authority: T.C.A. §§ 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111 and 71-5-117.

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

Date: 4/28/2016

Signature: [Handwritten Signature]

Name of Officer: Darin J. Gordon

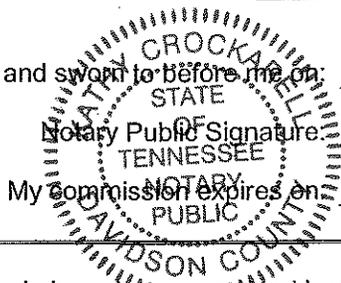
Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 4/28/16

Notary Public Signature: [Handwritten Signature: Kathy Crockarell]

My commission expires on: 1/8/2019



All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature: Herbert H. Slatery III]
Herbert H. Slatery III
Attorney General and Reporter

6/15/2016 Date

Department of State Use Only

Filed with the Department of State on: 6/16/16

Effective for: 180 *days

Effective through: 12/13/16

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

[Handwritten Signature: Tre Hargett]
Tre Hargett
Secretary of State

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G.O.C. STAFF RULE ABSTRACT

AGENCY: Department of State; Charitable Solicitations, Fantasy Sports and Gaming

SUBJECT: Rules Related to the Fantasy Sports Act; Fees

STATUTORY AUTHORITY: Tenn. Code Ann., Section 47-18-5611 (Chapter 978 of the Public Acts of 2016)

EFFECTIVE DATES: June 29, 2016, through December 26, 2016

FISCAL IMPACT: The Fantasy Sports Tax Act imposed a tax at a rate of six percent on adjusted revenues of fantasy sports operators from contests played by players located in Tennessee. According to the Department, the total estimated annual revenue from this tax is \$252,630, with 60 percent allocated to the general fund, 20 percent to local governments, 10 percent to an administrative fund and 10 percent to the Department of Revenue. These rules do not impact the revenue tax contained in the Act.

STAFF RULE ABSTRACT: This emergency rule implements the Fantasy Sports Act, which serves to license and regulate fantasy sports operators offering fantasy sports contests to Tennessee consumers. This emergency rule includes provisions related to required information and documents to be submitted with the application; annual financial and compliance audit requirements; requirements related to the consumer protection aspects of the legislation; and fees related to the licensure and operation of fantasy sports operators.

This emergency rule establishes a tiered fee schedule for fantasy sports operator licensure and license renewal. Licenses will be valid for one year before being subject to renewal. The licensure and renewal fee will range from \$1,000 to \$75,000 depending on the operator's annual adjusted revenue, multiplied by a resident percentage, equal to or greater than a particular sum of money.

In addition to the licensing and renewal fee, this emergency rule authorizes a \$25.00 administrative

fee for things such as a late payment or correction
or change of information.

Impact on Local Governments

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

This rule is not anticipated to have any impact on local government.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules implement the Fantasy Sports Act of 2016, which serves to license and regulate fantasy sports operators offering fantasy sports contests to Tennessee Consumers. These rules include provisions related to required information and documents to be submitted with the application; annual financial and compliance audit requirements; requirements related to the consumer protection aspects of the legislation; and fees related to the licensure and operation of fantasy sports operators.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The Fantasy Sports Act of 2016, which is part of the Tennessee Consumer Protection Act, T.C.A. 47-18-5601 *et seq.* requires the implementation of these rules. The Act authorizes fantasy sports operators to offer fantasy sports contests to Tennessee consumers in accordance with the provisions of the Act.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Prior to the implementation of this Act, it was estimated that more than 1,000,000 Tennesseans participated in fantasy sports contests annually. These Tennesseans will now be offered significant consumer protection through the provisions in this bill. Many fantasy sports operators supported the passage of the Fantasy Sports Act and many have provided input as these rules have been promulgated.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

On April 5, 2016, prior to the passage of the Fantasy Sports Act, the Attorney General issued Opinion No. 16-13, which stated that fantasy sports contests fall within the definition of illegal gambling, although they are a game of skill to a degree that separates them from being a lottery, the absence of which would make them constitutionally prohibited. The Attorney General's opinion specifically stated that the General Assembly has the power to exclude fantasy sports contests from the definition of gambling, as long as they are not otherwise constitutionally prohibited. The Fantasy Sports Act specifically exempts these fantasy sports contests from the definition of gambling. These rules serve to further expand the aspects of fantasy sports contests that make them a game of skill rather than a game of chance, e.g., the prohibitions against the use of auto-draft and unfair scripts.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

These rules set the fees for fantasy sports operators to obtain a license to operate from the Department of State. The Department has set fees at a level commensurate with what it expects to be the cost to oversee the regulation of the industry. Thus, the Department does not anticipate that there will be any increase or decrease in revenue from the fees contained herein.

The Fantasy Sports Act imposed a tax at a rate of 6% on adjusted revenues of fantasy sports operators from contests played by players located in Tennessee. The total estimated annual revenue from this tax is \$252,630, with 60% allocated to the general fund, 20% to local governments, 10% to an administrative fund and 10% to the Department of Revenue. These rules do not impact the revenue tax contained in the Act.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Mary Beth Thomas
General Counsel for Secretary of State Tre Hargett

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

Mary Beth Thomas
General Counsel for Secretary of State Tre Hargett

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

State Capitol, First Floor
Nashville, Tennessee 37243
(615) 741-2819
mary.beth.thomas@tn.gov

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

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 Nashville, TN 37243
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For Department of State Use Only

Sequence Number: 06-24-16
 Rule ID(s): 6209
 File Date (effective date): 6/29/16
 End Effective Date: 12/26/16

Emergency Rule Filing Form

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

Agency/Board/Commission:	Department of State
Division:	Charitable Solicitations, Fantasy Sports and Gaming
Contact Person:	Mary Beth Thomas
Address:	State Capitol, 1 st Floor, Nashville, Tennessee
Zip:	37215
Phone:	615-741-2819
Email:	mary.beth.thomas@tn.gov

Rule Type:

Emergency Rule

Revision Type (check all that apply):

- Amendment
 New
 Repeal

Statement of Necessity:

The Fantasy Sports Act, T.C.A. § 47-18-5601, et. seq, was enacted by the 109th General Assembly and contained numerous provisions which require further instructions via rule. Thus, these rules are promulgated as emergency rules in accordance with T.C.A. § 4-5-208(a)(5).

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1360-03-05	Rules Related to the Fantasy Sports Act
Rule Number	Rule Title
1360-03-05-.01	Purpose and Scope
1360-03-05-.02	Definitions
1360-03-05-.03	Initial Application for Licensure
1360-03-05-.04	Renewal Application for Licensure
1360-03-05-.05	Approval of Licensure
1360-03-05-.06	Registration of Players/Know Your Customer Requirements
1360-03-05-.07	Player Account Activity
1360-03-05-.08	Player Funds and Required Reserve
1360-03-05-.09	Account Monitoring to Prevent Misuse
1360-03-05-.10	Certain State Employees Prohibited From Playing
1360-03-05-.11	Annual Reporting and Audits
1360-03-05-.12	Schedule of Range of Civil Penalties for Violations of the Fantasy Sports Act
1360-03-05-.13	Additional Authorized Fees

(Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to http://tn.gov/sos/pub/Rulemaking%20Guidelines_July2014.pdf)

SUBSTANCE OF PROPOSED EMERGENCY RULES

CHAPTER 1360-03-05 RULES RELATED TO THE FANTASY SPORTS ACT

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1360-03-05-.08	Player Funds and Required Reserve
1360-03-05-.09	Account Monitoring to Prevent Misuse
1360-03-05-.10	Certain State Employees Prohibited From Playing
1360-03-05-.11	Annual Reporting and Audits
1360-03-05-.12	Schedule of Range of Civil Penalties for Violations of the Fantasy Sports Act
1360-03-05-.13	Additional Authorized Fees

1360-03-05-.01 PURPOSE AND SCOPE.

These rules are promulgated for the purpose of implementing the Fantasy Sports Act and for providing additional guidance to the fantasy sports industry and Tennessee consumers with regard to the operation of fantasy sports contests within the State of Tennessee and/or for the use of Tennessee citizens. These rules are also promulgated for the purpose of establishing appropriate fees for the application, licensure, and civil penalty components of the Fantasy Sports Act. These rules shall only apply to fantasy sports contests when an entry fee is paid by a fantasy sports player for participation in a fantasy sports contest.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.02 DEFINITIONS. As used in these rules, the following terms are defined as follows:

- (1) "Adjusted Revenue" means the amount equal to the total entry fees collected from all players (regardless of the players' location) entering the fantasy sports contest less winnings paid to players in the contest, for the fantasy sports operator's most recent fiscal year.
- (2) "Attorney General and Reporter" or "Attorney General" means the Attorney General and Reporter of the State of Tennessee or his or her authorized designee.
- (3) "Auto draft" means athlete selection offered by a fantasy sports operator that does not involve any input or control by a player.
- (4) "Beginning player" means any player who has entered fewer than fifty-one (51) contests offered by a single fantasy sports operator, and who has not qualified as a Highly Experienced Player.
- (5) "Clearly and conspicuously" means:
 - (a) To disclose in such a way that the disclosure is made through the same means through which the communication is presented.

- (b) Requires that if the communication is visual, the disclosure is placed in close proximity to relevant claims, expressed in clear and plain language and syntax, and the size, contrast, location, and other characteristics stand out from other visual elements so that the disclosure is prominently displayed and unavoidable.
 - (c) Requires that the disclosure is repeated if necessary, visible for a sufficient duration, and does not necessitate scrolling.
 - (d) Requires that if the communication is audio, the disclosure is presented at adequate volume and cadence, and
 - (e) Requires that the disclosure is made before the consumer makes a decision to accept an offer.
- (6) "Daily fantasy sports contest" is any fantasy sports contest other than a season-long fantasy sports contest, as defined herein.
- (7) "Entry fee" means any valuable consideration including, but not limited to, cash or a cash equivalent, that a fantasy sports operator requires in order to participate in a fantasy sports contest.
- (8) "Fantasy sports contest"
- (a) Means:
 - 1. An online simulated game in which players are subject to an entry fee to assemble imaginary teams of athletes;
 - 2. Players are offered an award or prize made known to the players in advance of the online simulated game; and
 - 3. The winning outcome of which reflects in part the relative knowledge and skill of the participants and is determined predominantly by the accumulated statistical results of the performance or finishing position of athletes in underlying amateur or professional competitions; and
 - (b) Does not include:
 - 1. A contest in which the operator allows the players to auto draft athletes or to choose between pre-selected teams of athletes;
 - 2. A contest that offers or awards a prize to the winner of, or athletes in, the underlying competition itself; and
 - 3. A contest where the winning outcome is based on the score, point spread, or any performance or performances of any single actual team or combination of teams or solely on any single performance of an athlete or participant in any single actual event.
- (9) "Fantasy sports contest platform" means any online method by which access to a fantasy sports contest is provided, including, but not limited to a website, smart phone, or other application providing access to a fantasy sports contest.
- (10) "Fantasy sports operator" means a person that offers fantasy sports contests through an online digital platform.
- (11) "Fantasy sports operator contractor" means any person or entity who works pursuant to an independent contract with a fantasy sports operator and who has access to nonpublic portions of the fantasy sports operator's office, the fantasy sports operator's nonpublic computer network, or the fantasy sports operator's proprietary information that may affect how the fantasy sports contest is played.
- (12) "Highly experienced player" means a person who has either:

- (a) Entered more than five hundred (500) contests offered by a single fantasy sports operator; or
 - (b) Won more than five (5) fantasy sports prizes, which the total value of the prizes is two thousand five hundred dollars (\$2,500) or more.
- (13) "Knowingly" means to have known or should have known.
 - (14) "Minor" means any person under eighteen (18) years of age.
 - (15) "Person" has the same meaning as defined in T.C.A. § 47-18-103.
 - (16) "Player" means a person who participates in a fantasy sports contest offered by a fantasy sports operator.
 - (17) "Private contest" means a fantasy sports contest established among players known to each other and the terms and any prize of which are not established by a fantasy sports operator.
 - (18) "Prize" means a prize, award, incentive, promotion, or anything of value, including, but not limited to, money, contest credits, merchandise, or admission to another fantasy sports contest.
 - (19) "Resident percentage" means, for each fantasy sports contest, the percentage, rounded to the nearest tenth of a percent (0.1%) of the total entry fees collected from Tennessee consumers divided by the total entry fees collected from all players, regardless of the players' location, of the fantasy sports contest.
 - (20) "Script" means a list of commands that a fantasy-sports-related computer program can execute and that are created by players, or by third parties for the use of players, to automate processes on a fantasy sports contest platform.
 - (21) "Season-long fantasy sports contest" means a fantasy sports contest offered by a fantasy sports operator that is conducted over an entire sports season.
 - (22) "Secretary of State" or "Secretary" means the Secretary of State for the State of Tennessee, or his or her authorized designee.
 - (23) "Tennessee consumer" means a consumer located in this state at the time the person enters a fantasy sports contest.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.03 INITIAL APPLICATION FOR LICENSURE.

- (1) Application information. Any person seeking to be a licensed fantasy sports operator shall submit an application to the Secretary of State, using a form available from the Secretary of State, with the following information:
 - (a) Name. The name of the applicant.
 - (b) Primary contact. The designated contact person for the applicant, a telephone number, address, and email address for that contact.
 - (c) Location. The physical address of the applicant's principal place of business.
 - (d) Disclosure of ownership. A complete disclosure of the true ownership of the fantasy sports operator as follows:
 - 1. For limited liability companies (hereinafter, "LLC"), including professional LLCs, provide the full name, address, and telephone number of each member of the LLC. If the member is not a natural person, disclose the true ownership of the member (and

successive levels of ownership, if necessary) until a natural person or another corporate entity is disclosed. If another corporate entity is disclosed, provide a complete disclosure of that corporate entity's ownership in accordance with the specific rules for that entity contained herein (and successive levels of ownership, if necessary).

2. For general, limited, or limited liability partnerships, provide the full name, address, and telephone number of each partner. If the partner is not a natural person, disclose the true ownership of the partner (and successive levels of ownership if necessary) until a natural person, or another corporate entity, is disclosed. If another corporate entity is disclosed, provide a complete disclosure of that corporate entity's ownership in accordance with the specific rules for that entity contained herein (and successive levels of ownership, if necessary).
 3. For a corporation, provide the full name, address, and telephone number of any natural person or entity having an ownership interest of five percent (5%) or more of the outstanding shares of the corporation. If a corporate entity is disclosed, provide a complete disclosure of that corporate entity's ownership in accordance with the specific rules for that entity contained herein (and successive levels of ownership, if necessary).
 4. The intent of this rule is to require, to the fullest extent that the individual or corporate structure of an applicant allows, disclosure of names of individual natural persons who have a significant ownership interest in a fantasy sports operator.
- (e) Criminal Record. The applicant's criminal record, if any, as specified below:
1. Information regarding the criminal record, if any, of the following:
 - (i) Each partner of a partnership;
 - (ii) Each member of a limited liability company;
 - (iii) Each director and officer of a non-publicly held corporation;
 - (iv) Each director and officer of a publicly held corporation, if that director or officer is involved in the day to day management of fantasy sports contests and operations; and
 - (v) Each stockholder of five percent (5%) or more of a corporation.
 2. An applicant, and the individuals identified in subpart (e)(1) above, shall have a duty to disclose on the application whether they have been convicted of a crime (other than traffic violations and convictions that have been expunged), and if so, the nature of the crime, the date, place of the conviction, and the legal disposition of the case.
 3. An applicant, and the individuals identified in subpart (e)(1) above, shall obtain a criminal background check (an "Identity History Summary") from the Federal Bureau of Investigation. The applicant must submit, with its application, either the completed Identity History Summary, or documentation showing that the Identity History Summary was requested prior to submitting the application.
 4. The applicant's application may be conditionally granted upon receipt of the self-disclosure of the criminal record information on the application and prior to receipt of the report(s) from the Federal Bureau of Investigation. However, the Secretary of State may immediately revoke the conditional approval of the fantasy sports operator's application if information is received on the Identity History Summary that contradicts the self-disclosure made on the application.
 5. Evidence of an applicant's (including any of the individuals identified in subpart (e)(1) above) conviction or plea of guilty or nolo contendere for a felony, or a misdemeanor

involving fraud, dishonesty, breach of trust, gambling, or moral turpitude, within the ten (10) years prior to the date of application shall be grounds for denial of an application.

- (f) Interest in other fantasy sports operators. Disclosure of any ownership interest held by (as applicable in accordance with the corporate structure of the entity) a policy making manager, a partner of a partnership, a member of a limited liability company, a director or officer of a corporation, a stockholder of five percent (5%) or more of a corporation, in any fantasy sports operator, or any entity previously or currently licensed by another entity that licenses fantasy sports operators or similar entities.
- (g) Description of operations. A description and address of any physical facility operated by the fantasy sports operator, if any, in this state, the number of employees, and the nature of the facility's business.
- (h) Information regarding player deposits.
 - 1. The applicant's policies and procedures for limiting each player to one continuous and active account.
 - 2. The applicant's policies and procedures for limiting individual player deposits to no more than two thousand five hundred dollars (\$2,500) per month.
 - 3. The applicant's policies and procedures for temporarily or permanently increasing a player's deposit limit, at the request of the player, to an amount above two thousand five hundred dollars (\$2,500) per month.
- (i) Information and documentation regarding the reserve, segregated account, or Escrow Fund Account established pursuant to Rules 1360-03-05-.08(2).
- (j) Information regarding verification of identity. A copy of the policies and procedures adopted to verify the identity of players seeking to establish accounts.
- (k) Confirmation of tax clearance. A certificate of tax clearance issued by the Commissioner of the Tennessee Department of Revenue which states that the applicant is current on all taxes, fees, and penalties to the satisfaction of the Commissioner; or a statement that the applicant has no current obligation to the Commissioner because it is a newly registered entity in Tennessee.
- (l) Confirmation of registration with the Division of Business Services. A statement that the applicant is registered with the Secretary of State's Division of Business Services, and the applicant's control number issued by the Division of Business Services.
- (m) Financial information. The fantasy sports operator shall provide the following initial financial information:
 - 1. The total amount of adjusted revenue earned by the fantasy sports operator for the prior fiscal year.
 - 2. A calculation of the resident percentage for the prior fiscal year.
 - 3. The total amount of all winnings earned by fantasy sports players (including non-Tennessee consumers) for the prior fiscal year.
 - 4. Audited financial statements prepared in accordance with the attestation standards established by the American Institute of Certified Public Accountants for the most recent completed fiscal year and audited or unaudited financial statements for the most recent completed fiscal quarter.
 - 5. The Secretary of State may inquire regarding additional financial information, or seek additional financial documentation, within his or her discretion.

- (n) Information and documents concerning operational compliance.
1. The applicant's policies and procedures related to the prevention of minor participation in fantasy sports contests.
 2. The applicant's policies and procedures related to advertisements, including the applicant's policies and procedures related to accurate representations concerning chances of winning and the number of persons winning.
 3. The applicant's policies and procedures related to the applicant's compliance with the Federal Trade Commission, Guides Concerning Use of Endorsements and Testimonials in Advertising, compiled in 16 CFR § 225.
 4. The applicant's policies and procedures relating to assistance available to problem gamblers.
 5. The applicant's policies and procedures relating to implementation and enforcement of self-limitations and self-exclusions requested by players.
 6. The applicant's policies and procedures related to protection of player deposits, including policies and procedures related to the following:
 - (i) Prevention of unauthorized withdrawals from player accounts by fantasy sports operators or others;
 - (ii) Reporting and responding to complaints by a player regarding the handling of the player's account; and
 - (iii) Closure of player accounts.
 7. The applicant's policies and procedures related to account monitoring to prevent misuse of accounts, including policies and procedures related to the following:
 - (i) Detection and prevention of misuse of proxy servers;
 - (ii) Location verification;
 - (iii) Prevention of the use of unauthorized scripts; and
 - (iv) Prevention of the use of pre-selected teams.
 8. The applicant's policies and procedures related to the prevention of unauthorized play by the following individuals:
 - (i) Fantasy sports operator employees, fantasy sports operator contractors, and any spouse, children, or parents of any sports operator employee or contractor;
 - (ii) Professional or amateur athletes whose individual statistics or performance may be used to determine any part of the outcome of a fantasy sports contest; and
 - (iii) Any sports agent, team employee, referee, or league official associated with any athletic competition that is the subject of fantasy sports contests.
 9. The applicant's policies and procedures relating to fantasy sports contests for beginning players, including policies and procedures related to the following:
 - (i) Explanation of contest play;

- (ii) Identification of highly experienced players, including symbols or other identification used;
 - (iii) Recommending beginning player only contests and low cost private contests;
 - (iv) Percentage of contests open only to beginning players and that exclude highly experienced players;
 - (v) Prevention of access by highly experienced players to beginner player contests directly or through a proxy; and
 - (vi) Suspension of accounts of highly experienced players who participate in contests for beginning players only.
10. The applicant's policies and procedures relating to the locking of fantasy sports contests.
 11. The applicant's policies and procedures relating to the restriction of the number of entries per fantasy sports contest per player.
- (2) The application shall be signed by an officer or director, member, or partner, as applicable in accordance with the fantasy sports operator's corporate structure and must include a notarized affirmation as follows:
- My name is _____ and I serve as the (title) of (fantasy sports operator). I swear or affirm to the best of my knowledge, information, and belief, that the information submitted on this application is true and correct, and that I have made a good faith effort to verify the information submitted herein.
- (3) The applicant shall submit a non-refundable application fee in the form of a check made payable to the Department of State in the amount of three hundred dollars (\$300). Review of the applicant's application will not begin until receipt of the application fee.
 - (4) The application, supporting documentation, and fee may be hand-delivered or mailed to the Office of the Secretary of State, Division of Charitable Solicitations, Fantasy Sports, and Gaming, attn: Director; at 312 Rosa L. Parks Blvd., 8th Floor, Nashville, Tennessee 37243.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.04 RENEWAL APPLICATION FOR LICENSURE.

- (1) Any person seeking to renew its application to be a licensed fantasy sports operator shall submit a renewal application, in a form available from the Secretary of State, no later than forty-five (45) days prior to the expiration of the prior year's license, containing the following information:
 - (a) All information required in an initial application, as set forth in Rule 1360-03-05-.04 except for the following:
 1. Identity History Summary from the Federal Bureau of Investigation for individuals who have previously submitted criminal background reports as part of the application process and who have not self-disclosed any new criminal history.
 2. Financial statements required by Rule 1360-03-05-.03(1)(m)(4).
- (2) The application shall be signed by an officer or director, member, partner, or individual otherwise authorized by the organization, as applicable in accordance with the fantasy sports operator's corporate structure and must include a notarized affirmation as follows:

My name is _____ and I serve as the (title) of (fantasy sports operator). I swear or affirm to the best of my knowledge, information, and belief, that the information submitted on this application is true and correct, and that I have made a good faith effort to verify the information submitted herein.

- (3) The applicant shall submit a nonrefundable renewal application fee in the form of a check in amount of three hundred dollars (\$300) made payable to the Department of State. Review of the applicant's renewal application will not begin until receipt of the application fee.
- (4) The renewal application, supporting documentation and fee may be hand delivered or mailed to the Office of the Secretary of State, Division of Charitable Solicitations, Fantasy Sports, and Gaming; attn: Director, at 312 Rosa L. Parks Blvd., 8th Floor, Nashville, Tennessee 37243.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.05 APPROVAL OF LICENSURE.

- (1) The Secretary of State shall review each license application and renewal application received and either approve or deny the application within thirty (30) days of receipt of a fully completed application, as determined by the Secretary of State. The Secretary of State has the discretion to approve or deny the application based on the adequacy of the information submitted and will notify the designated contact person of his or her decision by certified mail.
- (2) Each license issued shall be valid for a period of one (1) year following the date of notification of approval by the Secretary of State.
- (3) If the license, or renewal license, is granted, the licensee must remit payment in accordance with the following schedule, within ten (10) days of receipt of the notification letter approving (or conditionally approving) the application or renewal application.
 - (a) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, equal to or greater than \$2,000,000.....\$75,000.
 - (b) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, equal to or greater than \$1,000,000 but less than \$2,000,000..... \$50,000.
 - (c) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, equal to or greater than \$500,000 but less than \$1,000,000.....\$22,500.
 - (d) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, equal to or greater than \$100,00 but less than \$500,000.....\$10,000.
 - (e) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, equal to or greater than \$50,000 but less than \$100,000.....\$5,000.
 - (f) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, equal to or greater than \$10,000 but less than \$50,000.....\$2,500.
 - (g) For fantasy sports operators with annual adjusted revenue, multiplied by the resident percentage, less than \$10,000.....\$1,000.
- (4) Payments will be accepted in the form of a check made payable to the Department of State.
- (5) License fees are nonrefundable; however, if the applicant's license or renewal license has been granted conditionally in accordance with Rule 1360-03-05-.03 and is subsequently revoked due to the receipt of inconsistent information on a criminal background check report from any individual other than the individual signing the attestation, the Secretary of State shall refund the license fee to the applicant within thirty (30) days.

Statutory authority: T.C.A. § 47-18-5601.

- (1) Registration. Before allowing a player to create an account, including for free play, a fantasy sports operator must first collect:
 - (a) The name of the individual; and
 - (b) The individual's date of birth showing the individual is 18 years of age or older;
- (2) Deposits and withdrawals. No player shall be permitted to deposit or withdraw any funds until the individual has conducted the Identity Verification required by Rule 1360-03-05.06(4) and provided the following information:
 - (a) The physical address where the individual resides; and
 - (b) Any other information required by the fantasy sports operator to independently verify the identity of the player making a deposit or withdrawal.
- (3) Single account. A fantasy sports operator shall limit each player to one active and continuously used account. Fantasy sports operators shall implement rules and clearly and conspicuously publish procedures to terminate all accounts of any player that establishes or seeks to establish more than one username or more than one account, whether directly or by use of another person as a proxy. Such procedures may allow a fantasy sports player that establishes or seeks to establish more than one username or more than one account, for one time only, to retain one account provided that the fantasy sports operator investigates and makes a good faith determination that the fantasy sports player's conduct was not intended to obtain a competitive advantage. A player who has established more than one username or account will not be entitled to retain any winnings earned from any account during the time period that more than one username or account is active. A fantasy sports operator must require that any subsequent action by a player of establishing or seeking to establish more than one username or more than one account will result in the fantasy sports operator prohibiting that player from establishing another future account with that fantasy sports operator within a period of two years.
- (4) Identify verification. A fantasy sports operator shall use commercially and technologically reasonable means to independently verify the identity of the individual making a deposit or a withdrawal. Third party entities may be used to verify the identity of a player.
 - (a) If a fantasy sports operator determines that the information provided by a player to make a deposit or process a withdrawal is inaccurate or incapable of verification, or violates its policies and procedures, the fantasy sports operator shall, within ten days, require the submission of additional information that can be used to verify the identity of the player. If such information is not provided or does not result in verification of the player's identity, the fantasy sports player shall:
 1. Immediately suspend the player's account and not allow the player to participate in any further fantasy sports contests;
 2. Retain any winnings attributable to the player;
 3. Refund the balance of deposits made to the account to the source of such deposit or by issuance of a check; and
 4. Deactivate the account.
 - (b) Prior to verification of the player's identity in accordance with this rule, the player shall not be permitted to make deposits or withdraw funds from his or her account.

- (5) Username and password. A player must be provided with (or create) an electronic identifier such as a digital certificate or an account description and a password to log into an account on a fantasy sports contest platform.
 - (a) The fantasy sports operators must allow players to change their passwords and should remind them to do so on a regular basis.
 - (b) Where a player has forgotten his or her password, the fantasy sports operator must provide a secure process for the re-authentication of the player and the retrieval and/or resetting of the password. Any and all processes for dealing with lost player user IDs or passwords must be clearly described to the player and sufficiently secure.
 - (c) When a player logs into the fantasy sports platform, either the most recent time and date of login must be displayed, or the player must be able to access information listing the time and date of any contest entries and any withdrawals or deposits that have taken place in his or her account the last 30 days.
 - (d) Each fantasy sports contest must have a unique identifier assigned by the fantasy sports operator which distinguishes entries into that contest from entries into other contests.
- (6) Minors prohibited. Only players age 18 and over may participate in fantasy sports contests.
 - (a) A fantasy sports operator must deny account registration to any person who enters a birthdate which indicates that they are a minor;
 - (b) A fantasy sports operator shall implement commercially and technologically reasonable procedures to prevent access to fantasy sports contests by minors on its fantasy sports platform, including but not limited to independent verification of age using information obtained from independent sources outside of the player seeking to open an account. Third party services may be used to verify the age of a player; and
 - (c) A fantasy sports operator shall clearly and conspicuously display, on web pages that are accessed prior to registering for a fantasy sports contest, a statement that it is illegal for persons under the age of 18 to engage in fantasy sports contests in Tennessee. This statement must be clearly and conspicuously displayed by the fantasy sports operator.
- (7) Player affirmations. Fantasy sports operators, must include the following provisions in any Terms of Service or Terms of Use.
 - (a) That the information provided to the operator by the individual to register is accurate;
 - (b) That the individual has been informed, and acknowledges, that as an authorized player he or she is prohibited from allowing any other person access to or use of their fantasy sports player account; and
 - (c) That the individual acknowledges that his or her account activity and winnings may be disclosed to the Secretary of State, the Department of Revenue and any other applicable state or federal entities.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.07 PLAYER ACCOUNT ACTIVITY.

- (1) Amount of Monthly Deposits. No player shall be permitted to deposit more than two thousand five hundred dollars (\$2,500), of cash or a cash equivalent, per month with a fantasy sports operator unless the player demonstrates that he or she should be entitled to increase its monthly deposit limits in accordance with these rules and the published rules of the fantasy sports operator.
 - (a) No player shall be granted an increase in their deposit limit prior to verification of their identity in accordance with these rules.

- (b) No player who is classified as a beginning player shall be allowed to request an increase in their deposit limit.
 - (c) In order to be eligible for a deposit limit increase, a player must demonstrate, to the fantasy sports operator's reasonable satisfaction, that they qualify for an increase under policies and procedures established by the fantasy sports operator, based on the player's annual income or net worth.
 - (d) Fantasy sports operators shall establish and publish reasonable procedures for increasing a player's deposit limit, but in no circumstances shall such deposit limits be increased unless the player has an annual income of more than \$150,000 (or \$300,000 jointly with a spouse) or financial net worth greater than \$500,000, calculated as follows:
 - 1. Any individual whose net worth, or joint net worth with that individual's spouse, exceeds five hundred thousand dollars (\$500,000).
 - (i) For purposes of calculating net worth under this subsection, the individual's primary residence shall not be included as an asset;
 - (ii) Indebtedness that is secured by the individual's primary residence, up to the estimated fair market value of the primary residence at the time of the request for account increase, shall not be included as a liability (except that the amount of such indebtedness outstanding at the time of the request for account increase exceeds the amount outstanding sixty (60) days before such time, other than as a result of the acquisition of the primary residence, the amount of such excess shall be included as a liability; and
 - (iii) Indebtedness that is secured by the individual's primary residence in excess of the estimated fair market value of the primary residence at the time of the request for account increase shall be included as a liability;
 - 2. Any individual who had an individual gross income in excess of one hundred fifty thousand dollars (\$150,000) in each of the two (2) most recent years, or joint income with that individual's spouse in excess of three hundred thousand dollars (\$300,000) in each of those years and has a reasonable expectation of reaching the same income level in the current year.
- (2) Enforcement of self-exclusion. A fantasy sports operator must take all reasonable steps to immediately refuse service to or otherwise enact appropriate restrictions that prevent an individual who has set limitations in accordance with T.C.A. § 47-18-5605(a)(12) from entering fantasy sports contests. These policies and procedures include, without limitation, the following:
- (a) The maintenance of a registry of those individuals who have self-imposed limitations on their account, including the name, address, and account details of individuals who have self-imposed restrictions on their account.
 - (b) The closing of the player's account held by the individual who has self-excluded.
 - (c) Employee training to ensure enforcement of these policies and procedures; and
 - (d) Provisions precluding an individual who has self-excluded from being allowed to again engage in fantasy sports contests until a reasonable amount of time of not less than thirty (30) days has passed since the individual self-excluded.
 - (e) Fantasy sports operators shall take all reasonable steps to prevent any marketing material from being sent to an individual who has self-excluded.
- (3) Recordkeeping requirements. The fantasy sports operator shall maintain the following records, for a period of five (5) years, beginning with the date each player account was created, and make these

records available for inspection at the request of the Secretary of State or the Attorney General and Reporter:

- (a) The date of each fantasy sports contest played;
- (b) The classification of the player, i.e., Beginning or Highly Experienced;
- (c) The entry fee paid for each fantasy sports contest played;
- (d) The prize, if any, awarded for each fantasy sports contest played;
- (e) All deposits and withdrawals made from each account; and
- (f) The date and description of any self-imposed limitation taken by any player.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.08 PLAYER FUNDS AND REQUIRED RESERVE.

(1) Player funds.

- (a) A fantasy sports operator shall not allow a player to transfer funds to any other player.
- (b) After a player's identity has been verified, a player must be allowed to withdraw funds maintained in his or her account, whether such account is opened or closed. Such requests must be honored within five (5) business days of the request, unless the fantasy sports operator believes in good faith that the player engaged in either fraudulent conduct or other conduct that would put the fantasy sports operator in violation of the law, in which case the fantasy sports operator may decline to honor the request for withdrawal for a reasonable investigatory period until its investigation is resolved, provided that it gives notice to the player of the nature of the investigation of the account. For purposes of this provision, a request for withdrawal will be considered honored if it is processed by the fantasy sports operator notwithstanding a delay by a payment processor, credit card issuer, or the custodian of a financial account.
- (c) A fantasy sports operator shall not allow a player's account to be overdrawn unless caused by payment processing issues outside of the control of the fantasy sports operator.
- (d) A fantasy sports operator shall neither extend credit to a player nor allow the deposit of funds into an account that is derived from the extension of credit by affiliates or agents of the operator. For purposes of this subsection, credit shall not be deemed to have been extended where, although funds have been deposited into an account, the operator is awaiting actual receipt of such funds in the ordinary course of business.

(2) Protection of player funds and required reserve. Funds held in player accounts and all funds constituting prize funds owed, or that may be owed based on contest participation, to player accounts of Tennessee consumers shall be protected in one of the following ways (a) the creation and maintenance of a reserve as set forth in Rule 1360-03-05-.08(2)(a); (b) by deposit in a special purpose segregated account that is maintained and controlled by a properly constituted corporate entity as set forth in Rule 1360-03-05-.08(2)(b); or (c) by deposit in a qualified escrow account as set forth in Rule 1360-03-05-.08(2)(c).

- (a) Reserve. A fantasy sports operator may maintain a reserve in the form of cash, cash equivalents, an irrevocable letter of credit, a bond, or a combination thereof to protect player funds.
 - 1. The amount of the reserve shall be equal to, at a minimum, the sum of all authorized players' funds held in player accounts of Tennessee consumers for use in fantasy sports contests plus all prize funds that are owed, or that may be owed based on contest participation by Tennessee consumers, until payment is made on the prize.

2. The reserve agreements must reasonably protect the reserve against claims of the operator's creditors other than the authorized players for whose benefit and protection the reserve is established, and must provide that:
 - (i) The reserve is established and held in trust for the benefit and protection of authorized players to the extent the fantasy sports operator holds money in player accounts for players.
 - (ii) The reserve must not be released, in whole or in part, except upon written instruction or approval of the Secretary of State. The reserve must be available within sixty (60) days of the written demand or written instruction. If the reserve is released to the Secretary of State, he or she may interplead the funds in the Davidson County Chancery Court for distribution to the authorized players for whose protection and benefit the account was established and to other such persons as the court determines are entitled thereto, or shall take such other steps as necessary to effect the proper distribution of the funds, or may do both.
 - (iii) The fantasy sports operator may receive income accruing on the reserve, without obtaining permission from the Secretary of State.
 - (iv) The fantasy sports operator has no interest in or title to the reserve.
 - (v) Tennessee law and this section govern the agreements and the operator's interest in the reserve and income accruing on the reserve.
 3. If the reserve is maintained in the form of cash, cash equivalent, or an irrevocable letter of credit, it must be held or issued by a federally insured financial institution. If the reserve is maintained in the form of a bond, it must be written by a bona fide insurance carrier. Reserves in the form of cash, cash equivalent, and irrevocable letter of credit must be established pursuant to a written agreement between the fantasy sports operator and the financial institution or insurance carrier, but the fantasy sports operator may engage an intermediary company or agent to deal with the financial institution or insurance carrier, in which event the reserve may be established pursuant to written agreements between the fantasy sports operator and the intermediary, and the intermediary and the financial institution or insurance carrier.
 4. The proposed reserve arrangement is not effective for purposes of complying with Rule 1360-03-05-.08(2) until the Secretary of State's approval has been obtained.
 5. The reserve arrangement agreements may be amended only with the prior written approval of the Secretary of State.
- (b) Special purpose segregated account with a separate corporate entity. A fantasy sports operator may establish a special purpose segregated account that is maintained and controlled by a properly constituted corporate entity that is not the fantasy sports operator and whose governing board includes one or more corporate directors who are independent of the fantasy sports operator and of any corporation related to or controlled by the fantasy sports operator.
1. The special purpose segregated account with a separate corporate entity must hold, at a minimum, the sum of all authorized player funds held in player accounts of Tennessee consumers for use in fantasy sports contests, plus all prize funds that are owed or that may be owed, based on contest participation by Tennessee consumers, until payment is made on the prize.
 2. The special purpose segregated account must reasonably protect the funds against claims of the operator's creditors other than the authorized players for whose benefit and protection the special purpose segregated fund is established, and must provide that:

- (i) The segregated account is established and held in trust for the benefit and protection of authorized players.
 - (ii) The fantasy sports operator may receive income accruing on the segregated account. However, the fantasy sports operator has no interest in or title to the segregated account.
 - (iii) The funds in the segregated account held for the benefit of Tennessee consumers may only be distributed for the following:
 - (I) To the fantasy sports operator for payment to players upon completion of fantasy sports contests or otherwise for the reconciliation of player accounts;
 - (II) For income earned on the account, to the fantasy sports operator;
 - (III) To the Secretary of State in the event that the fantasy sports operator's license expires, is surrendered, or is otherwise revoked, The Secretary of State may interplead the funds in the Davidson County Chancery Court for distribution to the authorized players for whose protection and benefit the account was established and to other such persons as the court determines are entitled thereto, or shall take such other steps as necessary to effect the proper distribution of the funds, or may do both;
 - (IV) As authorized in writing in advance by any agreement approved by the Secretary of State.
3. The corporate entity must require a unanimous vote of all corporate directors to file bankruptcy.
 4. The corporate entity must obtain permission from the Secretary of State prior to filing bankruptcy or entering into receivership.
 5. The corporate entity must have articles of incorporation that prohibit commingling of funds with that of the fantasy sports operator except as necessary to reconcile the accounts of players with sums owed by those players to the fantasy sports operator.
 6. The corporate entity must be restricted from incurring debt other than to fantasy sports players pursuant to the rules that govern their accounts for contests.
 7. The corporate entity must be restricted from taking on obligations of the fantasy sports operator other than obligations to players pursuant to the rules that govern their accounts for contests.
 8. The corporate entity must be prohibited from dissolving, merging or consolidating with another company (other than a special purpose corporate entity established by another fantasy sports operator that meets the requirements of this section) while there are unsatisfied obligations to fantasy sports players.
- (c) A fantasy sports operator who solely operates season-long fantasy sports contests may establish a qualified escrow fund account for the benefit and protection of players' funds. This account will be maintained by a financial institution approved by the Secretary of State.
1. The fantasy sports operator must enter into and execute an escrow fund agreement, the form for which is available from the Secretary of State.
 2. The fantasy sports operator shall deposit in the escrow fund account the sum of all players' funds held in players' accounts belonging to Tennessee consumers for use in fantasy sports contests plus all prize funds that are owed, or may be owed, based on contest participation by Tennessee consumers, until payment is made on the prize.

3. All funds held in the escrow fund account shall be held, invested, and disbursed in accordance with the terms and conditions of the escrow fund agreement upon approval of the Secretary of State.
 4. The escrow fund agreement allows distribution of funds, and any income thereon, under very limited circumstances, and only upon express approval of the Secretary of State for the following:
 - (i) Distribution to the fantasy sports operator for payment to players upon completion of fantasy sports contests up to a maximum of four (4) times per year.
 - (ii) To the Secretary of State in the event that the fantasy sports operator's license expires, is surrendered, or is otherwise revoked. The Secretary of State may interplead the funds in the Davidson County Chancery Court for distribution to the authorized players for whose protection and benefit the reserve was established and to other such persons as the court determines are entitled thereto, or shall take such other steps as are necessary to effect the proper distribution of the funds, or may do both.
 - (iii) To allow for the distribution of income to the fantasy sports operator.
 5. The escrow fund account shall be available only to those fantasy sports operators who operate season-long fantasy sports contests that would require access to their escrow fund account for payment of claims no more than four (4) times per year.
- (d) Each fantasy sports operator shall submit to the Secretary of State all information and copies of documents verifying its proposed arrangements pursuant to Rule 1360-03-05-.08(2), including copies of the agreements described herein. The Secretary of State shall determine whether the agreements and arrangements satisfy the purposes and requirements of this section, may require appropriate changes, or withhold approval if they do not, and shall notify the fantasy sports operator of the determination.
 - (e) In the event that a fantasy sports operator's reserve, segregated account or escrow fund is not sufficient to cover, at a minimum, the sum of player funds held in player accounts belonging to Tennessee consumers for use in fantasy sports contests plus all prize funds that are owed or may be owed, based on contest participation by Tennessee consumers, until payment is made on the prize, the operator must, within twenty-four (24) hours, notify the Secretary of State of this fact in writing and must indicate the steps the fantasy sports operator has taken to remedy the deficiency.
 - (f) The Secretary of State may require that the reserve, segregated account, or qualified escrow fund, be increased to correct any deficiency or for good cause to protect authorized players.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.09 ACCOUNT MONITORING TO PREVENT MISUSE.

- (1) Proxy servers. Fantasy sports operators shall not allow fantasy sports players to use proxy servers for the purpose of misrepresenting their identity or location in order to engage in fantasy sports contests.
- (2) Location verification. In order to prevent the unauthorized use of a player's account, a fantasy sports operator offering daily fantasy sports contests must use technologically and commercially reasonable measures to reasonably detect the physical location of a player attempting to access his or her account and to monitor for simultaneous logins to a single account from geographically inconsistent locations. A fantasy sports operator may use a third party to provide these location services.
 - (a) The geolocation service or application must be able to perform as follows:

1. Detect location notwithstanding the use of a proxy server;
 2. Detect location when routing through a Virtual Private Network (VPN);
 3. Use GPS data when the player seeks access from a mobile device or network and prohibit users from entering contests or depositing funds if GPS is not turned on;
 4. Check location each time the player attempts to enter a contest or make a deposit.
 5. Utilize a mechanism to alert the fantasy sports operator if an account is being accessed from geographically inconsistent locations. For example, technology that alerts the fantasy sports operator that login locations were identified that would be impossible to travel between in the time reported.
- (b) The fantasy sports operator should implement procedures to disable account access if the fantasy sports operator receives information that an account is being accessed from a location that indicates that there is a likelihood of unauthorized or improper access.
- (3) Scripts. A fantasy sports operator shall not permit the use of unauthorized scripts that give players an unfair advantage over other players in fantasy sports contests and shall use commercially reasonable efforts to monitor for and prevent the use of such scripts.
- (a) Authorized scripts shall be programs or scripts that are incorporated as a game feature and shall be clearly and conspicuously published and thereby made available to all players.
- (b) A script that is not authorized under section (a) will be deemed to offer an unfair advantage over other players, for reasons including, but not limited to, its potential use to:
1. Facilitate entry of multiple contests with a single line-up;
 2. Facilitate changes in many line-ups at one time;
 3. Facilitate use of commercial products designed and distributed by third parties to identify advantageous game strategies; or
 4. Gather information about the performance of others for the purpose of identifying or entering contests against daily fantasy sports players who are less likely to be successful.
- (c) A fantasy sports operator may prohibit the use of any and all scripts.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-10 CERTAIN STATE EMPLOYEES PROHIBITED FROM PLAYING.

- (1) In addition to the individuals excluded from participation in fantasy sports contests pursuant to T.C.A. § 47-18-5605(a)(14), employees of the Secretary of State's office are excluded from participating in any fantasy sports contest involving a prize over five dollars (\$5.00) offered by any fantasy sports operator.
- (2) This subsection does not prohibit the Secretary of State from utilizing test accounts solely in order to measure or assess the functionality of the fantasy sports platform or the compliance with applicable laws and regulations; provided that these accounts must be closely monitored by the Secretary of State for any unauthorized use.
- (3) This section does not make a fantasy sports operator responsible for identifying Secretary of State employees participating in its contests.

Statutory authority: T.C.A. § 47-18-5601.

- (1) Annual Reports. No later than the first day of the fifth month following the close of the fantasy sports operator's fiscal year in which the fantasy sports operator was licensed, the fantasy sports operator shall submit a report to the Secretary of State containing the following information and documents pertaining to the prior fiscal year, or the portion of the prior fiscal year in which the fantasy sports operator was licensed:
 - (a) Tennessee consumer account information. The following information shall be submitted electronically (in either a Microsoft excel spreadsheet or a Microsoft access database) contained on a removable media device, e.g., a flash drive.
 1. The total number of Tennessee consumer accounts, broken down by beginning fantasy sports players and highly experienced fantasy sports players;
 2. The number of new accounts established by Tennessee consumers;
 3. The number of accounts closed by Tennessee consumers;
 4. The total amount of entry fees received from Tennessee consumers;
 5. The total amount of prizes awarded to Tennessee consumers;
 6. The number of Tennessee consumers who requested a deposit limit increase;
 7. The number of deposit limit increases granted to Tennessee consumers;
 8. The number of accounts in which a Tennessee consumer was identified as a minor and the action taken as a result;
 9. The number and amount of refunds given to Tennessee consumers;
 10. The number of Tennessee consumers who requested additional limitations on their accounts pursuant to T.C.A. § 47-18-5605(a)(11), and the action taken as a result; and
 11. The number of Tennessee consumers who requested that their accounts be permanently closed.
 - (b) The total amount of all winnings earned by fantasy sports players on online platforms supported by the fantasy sports operators.
- (2) Audit Reports. No later than the first day of the fourth month following the close of the fantasy sports operator's fiscal year in which the fantasy sports operator was licensed, the fantasy sports operator shall submit a full and complete copy of the audit prepared pursuant to T.C.A. § 47-18-5604. This audit shall include two components, a financial audit and a compliance audit as described below.
 - (a) Financial audit. The fantasy sports operator shall submit a financial audit, prepared by a certified public accountant consistent with the attestation standards established by the American Institute of Certified Public Accountants, of the fantasy sports operator's financial operations and handling of player accounts and funds pursuant to the Fantasy Sports Act.
 - (b) Compliance audit. The fantasy sports operator shall submit a performance audit, prepared by a testing laboratory recognized by the Secretary of State to verify compliance with the operational aspects of the Fantasy Sports Act, including those set forth in T.C.A. § 47-18-5605, and to verify the integrity of the computer operating systems used to operate the fantasy sports contests.
 1. The Secretary of State will post the names of entities approved to conduct compliance audits on its website.

2. A fantasy sports operator or testing laboratory can seek recognition of an alternative gaming laboratory for use in completing the compliance audit by submitting a written request to the Secretary of State. The Secretary of State will review the qualifications and experience of the gaming laboratory and determine whether to recognize that entity as an approved provider.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.12 SCHEDULE OF RANGE OF CIVIL PENALTIES FOR VIOLATIONS OF THE FANTASY SPORTS ACT.

- (1) The following violations may result in civil penalties from a minimum of five thousand dollars (\$5,000) to the maximum allowed by law:
 - (a) Failure to use technologically reasonable means to prevent the use of proxy servers.
 - (b) Failure to use commercially reasonable means to verify a player's true identity and/or location.
 - (c) Failure to retain any record required to be retained in accordance with T.C.A. § 47-18-5603(c) or these rules.
 - (d) Failure to report any information required to be reported to the Secretary of State pursuant to the Fantasy Sports Act or these rules.
 - (e) Failure to clearly and conspicuously disclose rules regarding fantasy sports contests.
 - (f) Failure to provide information concerning assistance available to problem gamblers, in accordance with T.C.A. § 47-18-5605(a)(10).
 - (g) Failure to implement and/or enforce policies related to a player's self-imposed limitations as required by T.C.A. § 47-18-5605(a)(11) and (12).
 - (h) Failure to timely submit the annual audit required by T.C.A. § 47-18-5604(a)(2).
 - (i) Any other violation not specifically listed herein.
- (2) The following violations may result in civil penalties from a minimum of ten thousand dollars (\$10,000) to the maximum allowed by law:
 - (a) Failure to restrict the number of allowable entries for fantasy sports contests in accordance with T.C.A. § 47-18-5605(a)(25).
 - (b) Knowingly allowing the use of unauthorized scripts, failing to monitor fantasy sports contests to detect the use of unauthorized scripts, and/or failing to follow the provisions of T.C.A. § 47-18-5605(a)(21)-(23).
 - (c) Violations of any of the requirements set forth in T.C.A. § 47-18-5605(a)(18)-(20) relating required disclosures, player activity, and fantasy sports contests involving beginning and experienced players.
 - (d) Misrepresenting the chances of winning and/or the number of persons willing fantasy sports contests, or failing to comply with the advertising requirements set forth in T.C.A. § 47-18-5605(a)(8) and (9).
- (3) The following violations may result in civil penalties from a minimum of fifteen thousand dollars (\$15,000) to the maximum allowed by law:
 - (a) Knowingly allowing the use of auto-draft by players or offering pre-selected teams to players.

- (b) Failure to limit each player to one (1) account and/or limit player deposits in accordance with T.C.A. § 47-18-5602(b)(7) and these rules.
 - (c) Failure to segregate player funds and/or maintain a player reserve in accordance with T.C.A. § 47-18-5602(b)(8) and (26) and these rules.
 - (d) Failure to implement and enforce the player fund protections set forth in T.C.A. § 47-18-5605(a)(13).
 - (e) Failure to implement and enforce the minor prevention protections set forth in T.C.A. § 47-18-5605 (a)(4)-(6).
- (4) The following violations may result in civil penalties from a minimum of twenty thousand dollars (\$20,000) to the maximum allowed by law:
- (a) Knowingly disclosing proprietary and nonpublic information or failing to monitor access to proprietary and nonpublic information in violation of T.C.A. § 47-18-5605(15) and/or (17)(B).
 - (b) Knowingly allowing a prohibited player to participate in a fantasy sports contest in violation of T.C.A. § 47-18-5605(14), (16), and/or (17).
- (5) The following violations may result in a civil penalties of twenty-five thousand dollars (\$25,000):
- (a) Knowingly submitting false or misleading information, whether oral or written, to the Secretary of State.
 - (b) Directly or indirectly operating or promoting to Tennessee consumers a fantasy sports contest, or promoting a fantasy sports contest from this state to consumers outside of the state, without a license.
 - (c) Knowingly allowing any minor to participate in any fantasy sports contest.
- (6) These civil penalties may be assessed in addition to suspension, refusal to renew, or revocation of a license issued by the Secretary of State. These civil penalties are cumulative and supplementary to any remedies or actions available to the Office of the Attorney General and Reporter under the Fantasy Sports Act or otherwise provided by law. These civil penalties are cumulative and supplementary to any criminal prosecution pursuant to T.C.A. § 39-17-503.
- (7) These civil penalties may be assessed by the Secretary of State for each and every violation of the Fantasy Sports Act. Repeat occurrences of the same violation may result in separate civil penalties for each violation.

Statutory authority: T.C.A. § 47-18-5601.

1360-03-05-.13 ADDITIONAL AUTHORIZED FEES.

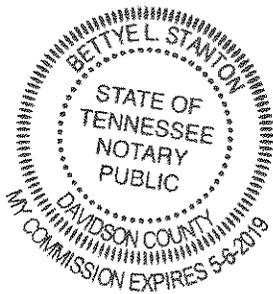
- (1) The Secretary of State is authorized to charge the following additional fees:
- (a) Late fee for any required filing.....\$25 per day.
 - (b) Correction of information fee.....\$25.
 - (c) Change of information fee.....\$25.

Statutory authority: T.C.A. § 47-18-5601.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

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



Date: June 28, 2016

Signature: Mamie Beth Thomas

Name of Officer: General Counsel, Mamie Beth Thomas

Title of Officer: General Counsel, Secretary of State

Subscribed and sworn to before me on: JUNE 28, 2016

Notary Public Signature: Bettye L. Stanton

My commission expires on: MAY 8, 2019

All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter
6/28/2016 Date

Department of State Use Only

Filed with the Department of State on: 6/29/16

Effective for: 180 *days

Effective through: 12/20/16

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

Tre Hargett
 Tre Hargett
 Secretary of State

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G.O.C. STAFF RULE ABSTRACT

AGENCY: Department of Financial Institutions

DIVISION: Credit Union

SUBJECT: Annual Credit Union Supervision Fee

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 45-4-1001(b)

EFFECTIVE DATES: August 30, 2016, through June 30, 2017

FISCAL IMPACT: None

STAFF RULE ABSTRACT: The proposed rule deletes Rule 0180-25-.01 concerning the annual credit union supervision fee. Public Chapter 241 of 2015 rewrote Tenn. Code Ann., Section 45-4-1002 to establish a statutory framework for calculating the annual credit union supervision fee, thereby rendering Rule 0180-25-.01 ineffective.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The repeal of Chapter 0180-25 and Rule 0180-25-.01 will not result in any change to the regulated activities of state-chartered credit unions.

Impact on Local Governments

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

The repeal of Chapter 0180-25 and Rule 0180-25-.01 will not have any impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

Public Chapter 241 of the Acts of 2015, effective April 24, 2015, amended T.C.A. § 45-4-1002, most significantly by establishing a new formula for determining the annual supervision fee that the Department assesses to state-chartered credit unions. Rule 0180-25-.01 sets forth processes and procedures for assessing and collecting that annual supervision fee. Public Chapter 241 incorporated certain language from Rule 0180-25-.01 pertaining to those processes and procedures into T.C.A. § 45-4-1002 and made several other substantive amendments. As a result, Public Chapter 241 rendered each provision of Chapter 0180-25 and Rule 0180-25-.01 ineffective and/or unnecessary.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. §§ 45-5-101 et seq., Uniform Administrative Procedures Act (UAPA), establishes provisions for rulemaking for Tennessee agencies; T.C.A. § 45-1-107 grants the commissioner of the Department of Financial Institutions power to enact reasonable substantive and procedural rules to carry out the purpose of any and all chapters within the commissioner's regulatory authority as conferred by law.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Although this chapter and rule apply to state-chartered credit unions, their repeal will not significantly impact any such institution, because, due to the enactment of Public Chapter 241, (i) various material operative provisions of this chapter and rule have been substantially incorporated into T.C.A. § 45-4-1002 (with modifications in certain instances) and (ii) each provision of this rule and chapter became ineffective and/or unnecessary. State-chartered credit unions are not likely to object to this repeal, as its impact is insignificant.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

There are no known attorney general opinions that directly relate to this rule.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

As each provision of this rule and chapter was rendered ineffective and/or unnecessary by the enactment of Public Chapter 241, the Department estimates that there will be no probable increase or decrease in state and local government revenues and expenditures resulting from the repeal of this rule and chapter.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Tina G. Miller, Deputy Commissioner; Daniel Espensen, Assistant General Counsel

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

Tina G. Miller, Deputy Commissioner; Daniel Espensen, Assistant General Counsel

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Tina G. Miller, Deputy Commissioner
Tennessee Tower, 26th Floor
312 Rosa L. Parks Avenue
Nashville, TN 37243
615-532-1030
Tina.g.miller@tn.gov

Daniel Espensen, Assistant General Counsel
Tennessee Tower, 26th Floor
312 Rosa L. Parks Avenue
Nashville, TN 37243
615-854-6177
daniel.espensen@tn.gov

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

None

**Department of State
Division of Publications**

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Nashville, TN 37243
Phone: 615-741-2650
Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 06-01-16
Rule ID(s): 6191
File Date: 6/1/16
Effective Date: 8/30/16

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by ten (10) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of ten (10) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Financial Institutions
Division:	Credit Union
Contact Person:	Daniel Espensen, Assistant General Counsel
Address:	Tennessee Tower, 26 th Floor, 312 Rosa L. Parks Avenue
Zip:	37243
Phone:	615-854-6177
Email:	daniel.espensen@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

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

Chapter Number	Chapter Title
0180-25	Rules Pertaining to the Assessment of the Annual Credit Union Supervision Fee
Rule Number	Rule Title
0180-25-.01	Annual Credit Union Supervision Fee

Chapter Number	Chapter Title
Rule Number	Rule Title

**RULES
OF THE
TENNESSEE DEPARTMENT OF FINANCIAL INSTITUTIONS**

**CHAPTER 0180-25 RULES PERTAINING TO THE ASSESSMENT OF THE ANNUAL CREDIT UNION
SUPERVISION FEE**

TABLE OF CONTENTS

~~0180-25-01. Annual Credit Union Supervision Fee.~~

~~0180-25-01. ANNUAL CREDIT UNION SUPERVISION FEE.~~

~~(1) Each credit union shall pay an annual supervision fee into the state treasury upon notice from the commissioner. All monies so collected by the commissioner shall be used in the administration of the Department of Financial Institutions and for no other purpose.~~

~~(2) The supervision fee shall be assessed against each credit union on a graduated scale in proportion to its assets, as reported on the credit union's June 30 Statement of Financial Condition (commonly known as the June 30 call report), according to the schedule set out in T.C.A. § 45-4-1002. The department's budget is accounted for on a fiscal year basis, July 1 through June 30. Any credit union that is a state credit union on the first day of a fiscal year shall pay the full credit union supervision fee for that fiscal year. The supervision fee shall not be prorated for any reason.~~

~~(3) Unless credit unions are notified otherwise by the department, the department shall send each credit union or its successor, notice of the credit union's supervision fee in December of the fiscal year in which the fee is being collected. The credit union shall pay this supervision fee within 30 days of receipt of the notice in order to avoid being assessed a late charge, as provided for in T.C.A. § 45-4-1002(c)(2). Notice of the supervision fee shall be given at the time a credit union merges, dissolves, liquidates or converts its charter, or at the time any other application is approved or any process completed that will result in a credit union ceasing to be a state chartered credit union, and the credit union or its successor shall pay the supervision fee within 30 days of receipt of the notice to avoid being assessed a late charge.~~

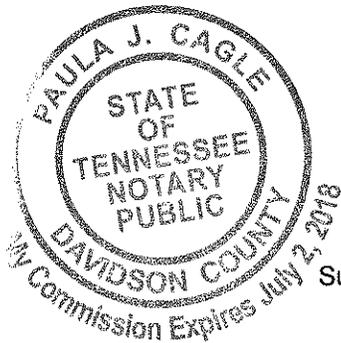
~~(4) If, for any reason, a credit union that was a state credit union on July 1, did not file a June 30 Statement of Financial Condition, then the commissioner shall determine that credit union's assets for purposes of making the assessment from other sources of information.~~

~~**Authority:** T.C.A. §§ 45-1-107, 45-4-1001 and 45-4-1002. **Administrative History:** Original rule filed February 28, 1994; effective June 28, 1994.~~

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Not applicable					

I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Commissioner of the Tennessee Department of Financial Institutions on 5/18/16, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.



Date: 5/18/16

Signature: Greg Gonzales

Name of Officer: Greg Gonzales

Title of Officer: Commissioner

Subscribed and sworn to before me on: Paula J. Cagle 5/18/16

Notary Public Signature: Paula J. Cagle

My commission expires on: 7/2/2018

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter
5/24/2016 Date

Department of State Use Only

Filed with the Department of State on: 6/1/16

Effective on: 8/30/16

Tre Hargett
 Tre Hargett
 Secretary of State

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G.O.C. STAFF RULE ABSTRACT

AGENCY: Board of Examiners for Nursing Home Administrators

SUBJECT: Administrators-in-Training and Administrators-in-Training Programs

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 63-16-103

EFFECTIVE DATES: September 7, 2016, through June 30, 2017

FISCAL IMPACT: None

STAFF RULE ABSTRACT: The rulemaking hearing rule authorizes the Board to deny an individual's acceptance into the Administrators-in-Training ("AIT") Program if the individual will not be eligible to receive Board approval to sit for the NAB examination upon completion of the AIT program.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no comments, either written or oral.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(1) The extent to which the rule or rule may overlap, duplicate, or conflict with other federal, state, and local governmental rules.

These proposed rule amendments do not overlap, duplicate, or conflict with other federal, state, and local governmental rules.

(2) Clarity, conciseness, and lack of ambiguity in the rule or rules.

These proposed rule amendments exhibit clarity, conciseness, and lack of ambiguity.

(3) The establishment of flexible compliance and/or reporting requirements for small businesses.

These proposed rule amendments do not establish any additional compliance and/or reporting requirements.

(4) The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.

These proposed rule amendments do not establish any additional compliance or reporting requirements.

(5) The consolidation or simplification of compliance or reporting requirements for small businesses.

These proposed rule amendments do not establish any additional compliance or reporting requirements.

(6) The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.

These proposed rule amendments do not establish performance standards for small business as opposed to design or operation standards required for the proposed rules.

(7) The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.

These rule amendments do not create entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Board of Examiners for Nursing Home Administrators

Rulemaking hearing date: 03/02/2015

- 1. Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

This rule amendment will affect those individuals seeking approval to enroll in the Administrator-in-Training Program offered by the Board of Examiners for Nursing Home Administrators. From January to August 2014, twenty-one (21) applications were received to participate in the Administrator-in-Training. Over the past three years there has been an average of 28.6 applications each year, which includes thirty-one (31) applicants in 2013; thirty-one (31) applicants in 2012; and twenty-four (24) applicants in 2011.

- 2. Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

This rule amendment will not affect reporting, recordkeeping or other administrative costs.

- 3. Statement of the probable effect on impacted small businesses and consumers:**

This proposed rule amendment should not have any effect on small businesses or consumers.

- 4. Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:**

There are no less burdensome, less intrusive or less costly alternative methods of achieving the purpose of this proposed rule amendment.

- 5. Comparison of the proposed rule with any federal or state counterparts:**

Federal: None.

State: At least thirty-seven other states have administrator-in-trainer programs, which have varying requirements as to whether the applicant shall meet all other licensure requirements at the time of completion of the A.I.T. program.

- 6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

This rule amendment does not provide for any exemptions for small businesses.

Impact on Local Governments

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

The proposed rule amendments should not have a financial impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

Rule 1020-01-.06 is amended by adding a sentence that will give the Board authority to deny an individual's acceptance into the Administrators-in-Training ("A.I.T.") Program if the individual will not be eligible to receive Board approval to sit for the NAB examination upon completion of the A.I.T. program.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

None.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

This rule amendment will affect those individuals seeking approval to enroll in the Administrator-in-Training Program offered by the Board of Examiners for Nursing Home Administrators. From January to August 2014, twenty-one (21) applications were received to participate in the Administrator-in-Training. Over the past three years there has been an average of 28.6 applications each year.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

These rules should not result in any increase or decrease in state or local government revenues or expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Kyonzte Hughes-Toombs, Deputy General Counsel, Department of Health.

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

Kyonzte Hughes-Toombs, Deputy General Counsel, Department of Health.

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Office of General Counsel, Department of Health, 665 Mainstream Drive, Nashville, Tennessee 37243, (615) 741-1611, Kyonzte.Hughes-Toombs@tn.gov.

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

None.

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Sequence Number: 06-06-16
Rule ID(s): 6197
File Date: 6/9/16
Effective Date: 9/7/16

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Board of Examiners for Nursing Home Administrators
Division:	Department of Health
Contact Person:	Kyonzte Hughes-Toombs, Deputy General Counsel
Address:	665 Mainstream Drive, Nashville, Tennessee
Zip:	37243
Phone:	(615) 741-1611
Email:	Kyonzte.Hughes-Toombs@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

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

Chapter Number	Chapter Title
1020-01	General Rules Governing Nursing Home Administrators
Rule Number	Rule Title
1020-01-.06	Preceptors, Administrators-in-Training and Administrators-in-Training Programs

1020-01-.05 TEMPORARY LICENSES. The Board may issue temporary licenses under limited circumstances pursuant to T.C.A. § 63-16-104(b).

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-16-103, and 63-16-104. **Administrative History:** Original rule certified June 7, 1974. Amendment by Public Chapter 969; effective July 1, 1984. Repeal and new rule filed December 17, 1991; effective January 31, 1992. Repeal and new rule filed December 14, 1999; effective February 27, 2000. Amendment filed July 31, 2000; effective October 14, 2000. Amendment filed January 23, 2002; effective April 8, 2002. Amendment filed February 20, 2002; effective May 6, 2002. Repeal and new rule filed September 4, 2003; effective November 18, 2003.

1020-01-.06 PRECEPTORS, ADMINISTRATORS-IN-TRAINING AND ADMINISTRATORS-IN-TRAINING PROGRAMS. ~~A person who intends to qualify for admission to the licensure examination by use of an A.I.T. program must first receive approval to begin the program by complying with rules 1020-01-.07 and 1020-01-.08, and successfully complete the program in a Board approved facility under the coordination, supervision and teaching of a Preceptor who has obtained certification from the Board pursuant to, and continues to meet the qualifications of this rule.~~

A person who intends to qualify for admission to the licensure examination by use of an A.I.T. program must first receive approval to begin the program by complying with rules 1020-01-.07 and 1020-01-.08, and successfully complete the program in a Board approved facility under the coordination, supervision and teaching of a Preceptor who has obtained certification from the Board pursuant to, and continues to meet the qualifications of this rule. The Board will not approve an individual for an A.I.T. program unless the individual is eligible to receive Board approval to take the NAB examination upon completion of the A.I.T. program.

(1) Preceptor - Qualifications for Certification.

(a) The following licensees may apply to receive certification as a Preceptor:

1. Any administrator; or
2. Any assistant administrator; or
3. A multifacility regional administrator. However, the A.I.T. program may be conducted only in facilities over which he or she is the regional administrator.

(b) An applicant must obtain from, complete and submit to the Board Administrative Office an application form along with satisfactory documentation of all the following:

1. Current licensure as a nursing home administrator in Tennessee.
2. One of the following:
 - (i) Valid licensure and full-time practice as a nursing home administrator for three (3) of the five (5) years immediately preceding application, the final year of practice must have been in Tennessee; or
 - (ii) Valid licensure as a nursing home administrator and employment as an assistant administrator with at least six (6) years of full-time experience in licensed nursing homes in the ten (10) years immediately preceding application.
3. Successful completion of seventy-two (72) semester hours or its equivalent of college credit. Each one (1) year of full-time experience obtained beyond the

(Rule 1020-01-.06, continued)

- three (3) or six (6) year qualifying time period may be substituted for twenty-four (24) semester hours of college credit.
4. Successful completion of a twelve (12) hour Board approved Preceptor Training and Orientation Course. The course must have been completed within the twelve (12) months immediately preceding certification. These hours may be applied to the annual C.E. requirement.
 5. Have no formal disciplinary actions taken against the applicant's license within the ten (10) years immediately preceding application which the Board deems to be of such a nature as to prevent the applicant from providing services as a Preceptor.
- (c) An applicant must attend an interview conducted by the Board or a Board member for discussion of basic concepts of the Preceptor Program. A major purpose of the interview will be to evaluate the training effectiveness of the preceptor. The Board may require that the interviews be electronically recorded and transcribed so that there will be no misunderstandings when the Board Member makes a presentation to the entire Board.
- (d) A preceptor may not supervise more than two (2) A.I.T.'s at one (1) time except by written permission of the Board.
- (2) Preceptor - Continued Certification.
- (a) To remain certified as a preceptor a licensee must:
1. on or before December 31st of every year after initial certification, successfully complete nine (9) clock hours of Board approved continuing education within the calendar year in addition to the continuing education hours required for licensure renewal pursuant to rule 1020-01-.12. Credit for six (6) hours of continuing education per year shall be given to a preceptor upon the successful completion of an A.I.T. program; and
 2. hold an active, current and unrestricted license in Tennessee as a Nursing Home Administrator; or
 3. hold an active, current and unrestricted license in another state as a Nursing Home Administrator and submit proof of successful completion of twenty-seven (27) clock hours of NAB-approved continuing education for every year the licensee practiced in another state while his/her Tennessee license was expired or retired. However, the continuing education hours required shall not exceed fifty-four (54) hours.
- (b) Failure to provide an A.I.T. an opportunity for adequate training under proper supervision in the administrative and operating activities and functions of a facility shall be grounds for discipline of a Preceptor's certification pursuant to T.C.A. § 63-16-108(a)(1) and rule 1020-01-.15.
- (c) Preceptor certification is subject to disciplinary action in the same manner and for the same causes as that for licensees.
- (d) When an A.I.T. fails the written licensure examination twice, the preceptor for the A.I.T. may, in the Board's discretion, be required to furnish a written assessment of the reasons for the failure or be required to appear before the Board to make an oral assess-

(Rule 1020-01-.06, continued)

ment. Failure of a preceptor to provide the written or oral assessment may be grounds for decertification.

(3) Administrator-In-Training Program.

(a) Facilities - Primary training and supervision of an A.I.T. must occur in one primary facility which is approved by the Board. If the Preceptor and the A.I.T. feel it would be beneficial to have certain areas of the training in a facility other than the primary one, the Preceptor shall notify the Board of the areas to be covered, the time to be spent in the secondary facility and the reasons. All facilities to be used must be approved in advance and in writing. The facility must obtain from, complete and submit to the Board Administrative Office an application form and documentation sufficient to show the following:

1. An organizational structure with clearly defined and staffed departments, each with a designated department head. Those departments must include:
 - (i) Administration;
 - (ii) Nursing;
 - (iii) Dietary;
 - (iv) Social services and activities;
 - (v) Medical records; and
 - (vi) Housekeeping, maintenance and laundry.
2. That the administrator serves as the department head of only the administration department of the facility.
3. The absence of outstanding operational deficiencies.
4. The most recent facility licensure survey and the plan of correction in response thereto.

(b) A.I.T. Program - Structure and Content. The A.I.T. programs must be conducted in Board approved facilities. The Preceptor must be either the administrator, assistant administrator or regional administrator of the primary facility. The program must comply with the following:

1. Prior to commencement of the A.I.T. program, a form must be obtained from, completed and submitted to the Board Administrative Office which contains all the following:
 - (i) Approval of the preceptor by the A.I.T. as evidenced by signature of both the Preceptor and A.I.T.;
 - (ii) The beginning date of the program;
 - (iii) The dates on which required reports are to be filed; and
 - (iv) The anticipated date of the A.I.T.'s completion of the program.

(Rule 1020-01-.06, continued)

2. The A.I.T. program shall cover a period of at least six (6) months during which period the A.I.T. shall devote full time and effort toward completion of the program. Should the A.I.T. spend less than full time, thus requiring more than six (6) months to complete, there must be prior written approval of the Board. The reasons for the delay shall be explained in writing by the Preceptor. Under no circumstances shall the program extend beyond one (1) year.
 3. The preceptor and the A.I.T. shall spend a minimum of four (4) hours per week in orientation, direct instruction, planning and evaluation. The minimum four (4) hours per week of training must occur in person in the facility or facilities approved by the Board for that individual's A.I.T. program.
 4. It shall be the responsibility of the preceptor to continually evaluate the development and experience of the A.I.T. to determine specific areas needed for concentration.
 5. A preceptor shall use the Board approved workbook as the basic guide. There shall be a pre-training assessment. If deemed advisable, additional material may be added to the basic guide to individually meet the needs of the A.I.T. While the basic guide may be expanded, no areas of the basic guide may be omitted.
 6. The preceptor and the A.I.T. shall submit reports on Board provided forms according to the following schedule:
 - (i) Every two (2) months after its commencement; and
 - (ii) A final report shall be submitted which contains a recommendation on licensure from the preceptor.
- (c) General Rules for A.I.T. Programs.
1. Change of Preceptor.
 - (i) If the approved preceptor is unable, for any reason, to fulfill the approved program of an A.I.T., a new preceptor shall be obtained as soon as possible, but no more than sixty (60) days from the date the A.I.T. first obtained knowledge that the training under the previous preceptor would be discontinued. In special circumstances the Board, upon application, may authorize additional time in which a new preceptor may be secured.
 - (ii) In the event an A.I.T. desires to secure a preceptor different from the one approved by the Board, the new preceptor and the A.I.T. shall notify the Board stating the reasons. New agreement forms shall be completed, signed by the new preceptor and the A.I.T., and be submitted to the Board Administrative Office for approval prior to continuing training.
 2. It shall be the duty of both the preceptor and the A.I.T. to notify the Board if the A.I.T. drops out of the program.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-16-103, 63-16-104, 63-16-106, 63-16-107, and 63-16-109.
Administrative History: Original rule certified June 7, 1974. Amendment filed November 12, 1982; effective December 13, 1982. Amendment filed February 3, 1983; effective March 7, 1983. Amendment filed April 19, 1984; effective May 19, 1984. Amendment filed February 23, 1987; effective April 9, 1987. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed January 4, 1989; effective February 18, 1989. Amendment filed August 14, 1989; effective September 28, 1989. Amendment filed September 8, 1989; effective October 23, 1989. Amendment filed February 21, 1991; effective

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Harold Walker	X				
Kathryn Wilhoit, RN PHD	X				
Juanita Honeycutt	X				
Florence Weierbach, PhD, MPH, RN	X				
Stephen J. D'Amico, MD	X				
Russell O. Caughron	X				
Craig Laman				X	
Barbara B. Trautman	X				
Vincent Davis	X				

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board of Examiners for Nursing Home Administrators (board/commission/ other authority) on 03/02/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 10/31/14 (mm/dd/yy)

Rulemaking Hearing(s) Conducted on: (add more dates). 03/02/15 (mm/dd/yy)

Date: 5-13-16

Signature: Kyonzte Hughes-Toombs

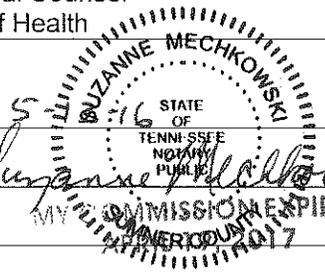
Name of Officer: Kyonzte Hughes-Toombs
Deputy General Counsel

Title of Officer: Department of Health

Subscribed and sworn to before me on: 5-13-16

Notary Public Signature: Suzanne Mechkowski

My commission expires on: MY COMMISSION EXPIRES PERIOD 2017



All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slaty III
Herbert H. Slatery III
Attorney General and Reporter

5/24/2016
Date

Department of State Use Only

Filed with the Department of State on: 6/9/16

Effective on: 9/7/16

Tre Hargett
Tre Hargett
Secretary of State

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G.O.C. STAFF RULE ABSTRACT

AGENCY: Board for Licensing Alarm Systems Contractors

SUBJECT: Fingerprinting

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 62-32-307

EFFECTIVE DATES: September 5, 2016, through June 30, 2017

FISCAL IMPACT: None

STAFF RULE ABSTRACT: The proposed rule generally requires that applicants for certification as an alarm systems contractor comply with the Board's background check requirement by submitting their fingerprints electronically to the TBI or an approved vendor rather than by submitting physical fingerprint cards to the Board. The Board reports that the TBI will no longer accept physical fingerprint cards from the Board. The rule will still allow for the submission of physical fingerprint cards in cases where good cause is shown.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The extent to which the rule may overlap, duplicate, or conflict with other federal, state, and local governmental rules:

There will be no overlap, duplication, or conflict with other federal, state or local governmental rules because the Board is the sole authority for establishing minimum requirements for fingerprinting of its licensees for a TN license.

2. Clarity, conciseness, and lack of ambiguity in the rule:

The rules are clear in purpose and intended application and not subject to varying interpretations.

3. The establishment of flexible compliance and reporting requirements for small businesses:

The amended rules create a less discretionary requirement for the submission of fingerprint applications by requiring electronic fingerprints, however it does provide for the board to allow fingerprint cards on a limited basis if authorized by the board.

4. The establishment of friendly schedules or deadlines for compliance and reporting requirements for small businesses:

There is no variation in reporting requirements for establishments in Tennessee of any size.

5. The consolidation or simplification of compliance or reporting requirements for small businesses:

These amendments address the requirement for obtaining electronic fingerprints and this rule simplifies the requirement in that the applicant can more easily obtain such by obtaining through a third party who will submit on their behalf.

6. The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule:

This amended rule by the board does not address performance standards.

7. The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs:

The amended rules intends to decrease barriers to obtain a license under this board. This amended rule provides a cheaper means in obtaining an electronic fingerprint. The current rule allows the state to process such for a cost of \$60. The amendment requiring the applicant to obtain through a third party costs \$38, which is a decrease of \$22 per applicant in obtaining such licensure.

Impact on Local Governments

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

There is no expected impact on local government by the promulgation of this amendment.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules amend the requirements for the submissions of fingerprints are required as a part of the application process for employee registration and qualifying applicants. Currently, the board rules allow applicants to submit physical fingerprint cards for processing. This amendment would only allow electronic fingerprints to be submitted and those must no longer be submitted to the Board but either directly to the TBI or to an approved vendor to provide to the TBI. This change was made necessary due to the TBI recently stating that it will no longer accept physical fingerprint cards from the board.

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

There is no known federal law, regulation or state law mandating promulgation of this rule.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All future employee registrants and qualifying agent applicants will be affected by these rules. Their position is unknown. The board members urge adoption of these rules.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

There are no known opinions of the attorney general and reporter or any judicial ruling that directly relates to this rule.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

There is no probable state increase or decrease in local government revenues and expenditures resulting from the promulgation of these rules.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Ashley N. Thomas
Assistant General Counsel
Division of Regulatory Boards
Department of Commerce and Insurance

Cody Vest
Executive Director – Alarm Systems Contractor Board
Division of Regulatory Boards
Department of Commerce and Insurance

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

Ashley N. Thomas
Assistant General Counsel

Division of Regulatory Boards
Department of Commerce and Insurance

Cody Vest
Director – Alarm Systems Contractor Board
Division of Regulatory Boards
Department of Commerce and Insurance

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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Ashley.thomas@tn.gov

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

These rules are being promulgated due to a memorandum dated February 3, 2015 from Brad Truitt, Tennessee Compact Office on behalf of the Tennessee Bureau of Investigations. The memo states that effective March 1, 2015, all agencies submitting fingerprints for civil purposes (which applies to this board in all cases) will no longer submit physical fingerprint cards for processing. The memo states that third party vendors may be used to convert physical cards into electronic format. There are also vendors who can take electronic prints directly from the hand. The current rules of the board require physical fingerprint cards for application. Given that the TBI will no longer accept such, it is necessary to amend the application requirements regarding fingerprinting to reflect acceptable processing by the TBI.

**Department of State
Division of Publications**

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Nashville, TN 37243
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For Department of State Use Only

Sequence Number: 06-05-16
Rule ID(s): 6196
File Date: 6/7/16
Effective Date: 9/5/16

Proposed Rule(s) Filing Form

Proposed rules are submitted pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-207, and 4-5-229 in lieu of a rulemaking hearing. It is the intent of the Agency to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within ninety (90) days of the filing of the proposed rule with the Secretary of State. To be effective, the petition must be filed with the Agency and be signed by twenty-five (25) persons who will be affected by the amendments, or submitted by a municipality which will be affected by the amendments, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly. The agency shall forward such petition to the Secretary of State.

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, board or entity in accordance with § 4-29-121(b).

Agency/Board/Board:	Alarm Systems Contractors Board
Division:	Division of Regulatory Boards Department of Commerce and Insurance
Contact Person:	Ashley N. Thomas
Address:	Davy Crockett Tower 500 James Robertson Pkwy Nashville, Tennessee
Zip:	37243
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Email:	Ashley.thomas@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

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

Chapter Number	Chapter Title
0090-01	General Provisions
Rule Number	Rule Title
0090-01-.05	Employee Registration Requirements
0090-01-.06	Qualifying Agent Requirements
0090-01-.12	Fingerprinting
0090-01-.13	Adding Classifications

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://sos.tn.gov/sites/default/files/forms/Rulemaking_Guidelines_August2014.pdf)

Chapter 0090-01
General Provisions
Amendments

Rule 0090-01-.05 Employee Registration Requirements is amended by deleting paragraph (2) and substituting instead the following language:

~~(2) An employee registration applicant shall either obtain electronically scanned fingerprints placed on standard FBI/TBI applicant cards through a company that has contracted with the State of Tennessee to provide a fingerprinting service or the applicant shall provide the Board with three (3) sets of classifiable fingerprints on standard FBI/TBI applicant cards for processing by the TBI/FBI.~~

(2) An employee registration applicant shall be deemed to have supplied the required sets of fingerprints if that applicant causes a private company contracted by the State to electronically transmit that applicant's classifiable prints directly to the Tennessee Bureau of Investigation (TBI) and Federal Bureau of Investigation (FBI) to forward an electronic report based on that applicant's fingerprints to the board. The employee registrant applicant or the alarm contractor employer on behalf of the applicant shall make the arrangements for the processing of his or her fingerprints with the company contracted by the State to provide electronic fingerprinting services directly and shall be responsible for the payment of any fees associated with processing of fingerprints to the respective agent authorized by the TBI and FBI.

(a) Provided, however, that the board may authorize the submission of three (3) sets of classifiable physical fingerprint cards, at the expense of the applicant and rolled by a qualified person acceptable to the board, for good cause.

Authority: T.C.A. §§ 62-32-307, 62-32-307(a), 62-32-307(b), 62-32-307(g), 62-32-307(h), 62-32-312, 62-32-342(d), 62-32-318, and 62-32-320.

Rule 0090-01-.05(10) is amended by deleting the phrase "fingerprint cards" and substituting instead the language "classifiable fingerprints" so that, as amended, the paragraph shall read:

(10) A registration applicant is not eligible to transfer to another alarm systems contractor while still under application. An applicant who does not complete the application process to become a registrant prior to changing employment to another alarm systems contractor shall be required to reapply and shall submit a new application under the new alarm systems contractor, along with the appropriate application fees, ~~fingerprint cards~~ classifiable fingerprints, and photos.

Authority: T.C.A. §§ 62-32-307, 62-32-307(a), 62-32-307(b), 62-32-307(g), 62-32-307(h), 62-32-312, 62-32-342(d), 62-32-318, and 62-32-320.

Rule 0090-01-.06 is amended by deleting paragraph (2) and substituting instead the following language:

~~(2) A qualifying agent applicant shall either obtain electronically scanned fingerprints through a company that has contracted with the State of Tennessee to provide a fingerprinting service or the applicant shall provide the Board with three (3) sets of classifiable fingerprint cards for processing by the TBI/FBI.~~

(2) A qualifying agent applicant shall be deemed to have supplied the required sets of fingerprints if that applicant causes a private company contracted by the State to electronically transmit that applicant's classifiable prints directly to the Tennessee Bureau of Investigation (TBI) and Federal Bureau of Investigation (FBI) to forward an electronic report based on that applicant's fingerprints to the board. The

qualifying agent applicant shall make the arrangements for the processing of his or her fingerprints with the company contracted by the State to provide electronic fingerprinting services directly and shall be responsible for the payment of any fees associated with processing of fingerprints to the respective agent authorized by the TBI and FBI.

- (a) Provided, however, that the board may authorize the submission of three (3) sets of classifiable physical fingerprint cards, at the expense of the applicant and rolled by a qualified person acceptable to the board, for good cause.

Rule 0090-01-.06(10) is amended by deleting the phrase "fingerprint cards" and substituting instead the language "classifiable fingerprints" so that, as amended, the paragraph shall read:

- (10) A qualifying agent applicant is not eligible to transfer to another alarm systems contractor while still under application. An applicant who does not complete the application process to become a licensed qualifying agent prior to changing employment to another alarm systems contractor shall be required to reapply and shall submit a new application under the new alarm systems contractor, along with the appropriate application fees, fingerprint cards classifiable fingerprints, and photos.

Authority: T.C.A. §§ 62-32-303, 62-32-304, ~~62-32-304(b)~~, 62-32-307, 62-32-307(a), ~~62-32-307(c)~~, ~~62-32-307(d)~~, ~~62-32-307(g)~~, ~~62-32-307(i)~~, ~~62-32-307(l)~~ 62-32-313, 62-32-316, ~~62-32-316(b)~~, and 62-32-320.

Rule 0090-01-.12 is amended by deleting the rule in its entirety and substituting instead the following language:

- (1) All applicants for employee registration or qualifying agent license shall be subject to a Federal Bureau of Investigations(FBI)/Tennessee Bureau of Investigations (TBI) background investigation pursuant to Tenn. Code Ann. §§ 62-32-312(e) and 62-32-313(b).
- ~~(2) In order to expedite the application process, an applicant may obtain electronically scanned fingerprints on standard FBI/TBI cards through any company that has contracted with the State of Tennessee to provide an electronic fingerprinting service. The applicant shall be GENERAL PROVISIONS CHAPTER 0090-01 (Rule 0900-01-.12, continued) June, 2012 (Revised) .14 deemed to have provided the Board with sets of classifiable prints if he or she causes a private company contracted by the State to electronically transmit the applicant's classifiable prints directly to the FBI and TBI and to forward a classifiable hard copy of the applicant's fingerprints to the Board on standard FBI/TBI applicant cards. The Board shall notify each applicant in writing of the name, address, and telephone number of any company contracted by the State to provide such service. All qualifying agent and registered employee applicants shall comply with the following requirements regarding payment for the fingerprinting service:~~
- ~~(a) If the applicant chooses to use the services of a company that has contracted with the State to provide an electronic fingerprinting service, then the applicant shall make the arrangements for the processing of his or her fingerprints with the company directly and shall be responsible for payment of any fees associated with the processing of fingerprints to the respective agency.~~
- ~~(b) If the applicant chooses to request that the Board process the fingerprint cards, then the applicant shall submit three (3) sets of classifiable fingerprint cards, on cards provided by the Board, with his or her application for processing through the FBI and TBI. The applicant shall pay to the Board all processing fees established by the TBI and FBI.~~
- ~~(c) In the event that the contracting company no longer contracts with the State to provide an electronic fingerprinting service, then the applicant shall submit three (3) classifiable fingerprint FBI/TBI cards with his or her application and shall pay to the Board all processing fees established by the TBI and FBI.~~

- (2) An applicant for employee registration or qualifying agent license required to submit fingerprints with his or her application for the purpose of allowing the board to forward the fingerprints to the TBI and FBI as required by T.C.A. §§ 62-32-312(e) and 62-32-313(b) shall make the arrangements for the processing of his or her fingerprints with the company contracted by the State to provide electronic fingerprinting services directly and shall be responsible for the payment of any fees associated with processing of fingerprints to the respective agent authorized by the TBI and FBI. The board shall notify every applicant in writing of the name, address and telephone number of any company contracted by the State to provide such a service. All alarm employee registration and qualifying agent applicants shall comply with the following requirements regarding payment for the fingerprinting service:
- (a) The board may authorize the submission of three (3) sets of classifiable physical fingerprint cards in lieu of electronic fingerprints, as required above, at the expense of the applicant and rolled by a qualified person acceptable to the board, for good cause;
 - (b) All sets of classifiable fingerprints required by this rule shall be furnished at the expense of the applicant;
 - (c) In the event the State no longer contracts with any company to provide an electronic fingerprinting service, then the applicant shall submit three (3) classifiable TBI and FBI fingerprint cards with his or her application and shall pay the board all processing fees established by the TBI and FBI.
 - (d) Applicants shall in all cases be responsible for paying application fees as established by the board regardless of the manner of fingerprinting.
- (3) In the event that a qualifying agent or employee registration ~~an~~ applicant furnishes unclassifiable fingerprints or fingerprints that are unclassifiable in nature to the board, or the TBI or FBI, the board may refuse to issue the requested license or registration. For the purposes of this rule, "unclassifiable fingerprints" means that the electronic scan or the print of the person's fingerprints cannot be read, and therefore cannot be used to identify the person. Should an applicant's fingerprints be rejected by the TBI or FBI, the applicant shall pay any fees assessed by the TBI or FBI for resubmission.
- (4) In the event an applicant's fingerprint cards are rejected by the TBI or the FBI two (2) times, the applicant shall submit new fingerprint cards along with payment of any fees charged by the TBI or FBI for processing of such fingerprints prior to the third submission. that the fingerprints submitted by an applicant are rejected or otherwise unable to be processed by the TBI and/or FBI, the applicant shall submit new fingerprints together with any additional fee(s) charged by the TBI and/or FBI for processing the new fingerprint card.

Authority: T.C.A. §§ 62-32-307, ~~62-32-307(a), 62-32-307(d), 62-32-307(g), 62-32-312, 62-32-312(d)(1), 62-32-312(e), 62-32-313, 62-32-313(b), and 62-32-318.~~

Rule 0090-01-.13(1) is deleting the phrase "fingerprint cards" and substituting instead the language "classifiable fingerprints" so that, as amended, the paragraph shall read:

(1) Qualifying Agent License

If a licensed qualifying agent wishes to add an alarm systems contractor classification to his or her license, then he or she shall make written application to the Board on such forms as are prescribed by the Board. The application shall be accompanied by an application fee as set by the Board. An applicant shall receive a license if the requirements of ~~Tenn. Code Ann. T.C.A. § 62-32-313(c) and (d)~~ as described in these rules have been met and all requisite fees have been paid. Submission of ~~fingerprint cards~~ classifiable fingerprints shall not be required to add a classification to an "active" qualifying agent license. If the licensee is qualified based on ~~Tenn. Code Ann. T.C.A. § 62-32-313(c) (1) or (2)~~, the requirements of rule 0090-05-.01(4) must be satisfied prior to the first renewal after adding the "fire" classification.

Authority: T.C.A. §§ ~~62-32-313(e), 62-32-313(d), 62-32-313(e), 62-32-314(a)(4), 62-32-314(c), 62-32-314(d), and 62-32-316(b).~~

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Vivian L. Hixson	X				
McKenzie C. Roberts	X				
Karen D. Jones				X	
William Scott Crockett	X				
John Keith Harvey				X	

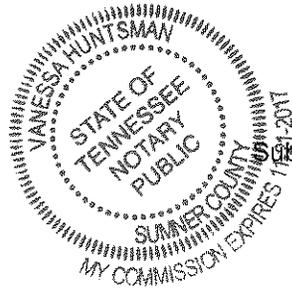
I certify that this is an accurate and complete copy of proposed rules, lawfully promulgated and adopted by the Tennessee Alarm Systems Contractors Board on 03/19/2015, and is in compliance with the provisions of T.C.A. § 4-5-222. The Secretary of State is hereby instructed that, in the absence of a petition for proposed rules being filed under the conditions set out herein and in the locations described, he is to treat the proposed rules as being placed on file in his office as rules at the expiration of ninety (90) days of the filing of the proposed rule with the Secretary of State.

Date: 4/26/16

Signature: Ashley N. Thomas

Name of Officer: Ashley N. Thomas

Title of Officer: Assistant General Counsel



Subscribed and sworn to before me on: 4/26/16

Notary Public Signature: Vanessa Huntsman

My commission expires on: 11/21/17

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
 Herbert H. Slatery III
 Attorney General and Reporter

5/26/2016
 Date

Department of State Use Only

Filed with the Department of State on: 6/7/16

Effective on: 9/15/16

Tre Hargett
 Tre Hargett
 Secretary of State

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G.O.C. STAFF RULE ABSTRACT

AGENCY: Department of Tourist Development

DIVISION: Administration

SUBJECT: Guidelines for Organization Applying for Tourist Promotion Matching Funds

STATUTORY AUTHORITY: Tennessee Code Annotated, Section 4-3-2207

EFFECTIVE DATES: September 1, 2016, through June 30, 2017

FISCAL IMPACT: According to the Department, there will be a probable increase in state and local government revenues and expenditures as a result of the promulgation of the rule. The rule will increase the maximum amount of state matching funds and the funding ratio from \$1.00 to \$2.00 in state matching funds for every \$1.00 of locally raised funds which regional tourism promotional organizations may apply for pursuant to T.C.A. Section 4-3-2207(b) and these revisions (also reflected in the underlying statute) may result in an increase in state and local revenue although the amount of such an increase cannot be determined from the data presently available to the Department.

STAFF RULE ABSTRACT: According to the Department, the purpose of the rulemaking hearing rule is to update the Department's Matching Grant rules to conform to revisions in state law. The revisions to state law include:

1. An increase of the maximum liability amount of state matching grant monies payable to each regional tourism promotion organizations from \$25,000 to \$35,000 each fiscal year;
2. An expansion of the types of business entitles which are entitled to receive matching state funds to include regional tourism promotion organizations which are tax exempt as well as chartered, non-profit organizations (See Tenn. Code Ann., Section 4-3-2207(b)); and
3. To increase the state match from \$1.00 to \$2.00 for each \$1.00 received by a regional tourism promotion organization as membership fees or donations as set forth in Tenn. Code Ann., Section 4-3-2207(b). The match was previously \$1.00 of state funding for every

\$1.00 received by a regional tourism promotion organization as membership fees and/or donations.

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

There were no comments received during the public comment period.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule affects small businesses.

- (1) The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule.

The proposed rule impacts the State's regional tourism promotion organizations established by Executive Order No. 19 by Governor Buford in 1968. That Executive Order established nine (9) regional tourism promotion organizations which cover all of the State of Tennessee and it has now been incorporated into Tennessee Code Annotated Section 4-3-2207(b). The impact on small business in the hospitality industry which includes restaurants, hotels, attractions, sporting goods stores, sporting venues and other travel-related businesses both in urban and rural areas will indirectly benefit from the additional State tourism dollars available to the regional, tourism promotion organizations.

- (2) The projected reporting, recordkeeping, and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record.

The recordkeeping, reporting and administrative costs required to comply with the proposed rules and the level of professional skills necessary for preparation of the records is minimal to the nine (9) regional tourism promotion organizations. The Department has an established procedure including a checklist of all the required documents each regional tourism promotional organization must furnish the State to apply for State matching funds each State fiscal year. Each regional tourism promotional organization has a managing director who has the responsibility to submit the documents required to receive State matching funds. The State checklist is a list of the items necessary for a regional tourism promotion organization to receive State matching funds and the checklist is sent to each regional tourism promotion organization several times during the course of the State fiscal year to assist the heads of the regional organizations with the necessary recordkeeping, reporting and administrative duties to receive State matching funds. The State also assists the tourism promotion regional organizations by: Answering questions; reviewing submitted documents; sending reminders about outstanding documents; and, notifying organizations of any issues which may arise concerning an organization's request for matching funds.

- (3) A statement of the probable effect on impacted small businesses and consumers.

The proposed rules will have a minimal impact on small businesses and consumers. The rules are applicable only to the State's nine (9) regional tourism promotional organizations established by the former State Planning Commission and Executive Order 17 and are now incorporated in the Tennessee Code Annotated. The impact on small businesses and/or consumers will not be significant other than to perhaps provide more State funding for the tourism promotion organization in regions throughout Tennessee. The rules were designed to provide additional tourism promotion dollars from the State to regional tourism promotional organizations across the State of Tennessee which has been in place for several decades. The additional tourism dollars assist in promoting each region of the State with the goal being to bring more tourists to each region which in turn results in increased sales and hotel tax revenue for the various regions in Tennessee. The existing rules provide only a maximum of \$25,000 in State matching funds to regional tourism promotion organizations; however, that amount has been increased to \$35,000 pursuant to T.C.A. Section 4-3-2207(b) and that increase is incorporated in this amendment. In addition, T.C.A. Section 4-3-2207(b) also increased the State's available matching funds from \$1.00 to \$2.00, therefore for every \$1.00 raised by members of the State's regional tourism promotion organizations as either membership fees or donations, the State will pay the regional tourism promotion organization \$2.00 in State Matching Funds up to the maximum liability amount of the grant contract for a given fiscal year and this increase is also incorporated in this amendment. The proposed amendments to the rules will incorporate the additional State funding available to regional tourism promotion organizations so that the rules are consistent with provisions of the Tennessee Code Annotated.

- (4) A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business.

The existing as well as proposed amendments to the rules are not burdensome, intrusive or costly for small businesses because the rules are not applicable to small businesses. The proposed rules apply only to the State's regional tourism promotional organizations and are designed to provide additional tourism dollars to Tennessee's nine (9) regional tourism promotional organizations which include: i) Greater Nashville Regional Council; ii) Memphis Area Association of Governments; iii) Middle East Tennessee Tourism Council; iv) Northeast Tennessee Association; v) Northwest Tennessee Tourism; vi) South Central Tennessee Tourism Association; vii) Southeast Tennessee Developmental District; viii) Tourism Association of Southwest Tennessee; and, ix) Upper Cumberland Tourism Association.

- (5) A comparison of the proposed rule with any federal or state counterparts.

The proposed rules have no federal or state counterparts.

- (6) Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.

An exemption of small businesses from all or any part of the requirements contained in the proposed rules is not necessary because the rules have little impact on small businesses other than to potentially increase the revenue for such businesses in the hospitality and tourism industry.

Impact on Local Governments

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

The Department anticipates that these amended rules will have a beneficial financial impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The purpose of the amendments to the rules is to update the Tennessee Department of Tourist Development's Matching Grant rules to conform to revisions in the Tennessee Code Annotated ("T.C.A."). The revisions to the T.C.A. include: i) An increase of the maximum liability amount of State matching grant monies payable to each regional tourism promotion organizations from \$25,000 to \$35,000 each fiscal year; ii) an expansion of the types of business entities which are entitled to receive matching State funds to include regional tourism promotion organizations which are tax exempt as well as chartered, non-profit organizations (See T.C.A. Section 4-3-2207(b)); and, iii) to increase the State match from \$1.00 to \$2.00 for each \$1.00 received by a regional tourism promotion organization as membership fees or donations as set forth in T.C.A. Section 4-3-2207(b). The match had previously been \$1.00 of State funding for every \$1.00 received by a regional tourism promotion organization as membership fees and/or donations.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Amendments to Chapter 1670-05-01 Guidelines for Organization Applying for Tourist Promotion Matching Funds are being adopted pursuant to Tennessee Code Annotated, Sections 4-3-2201, et seq.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

All of the nine (9) regional tourism promotional organizations were notified of amendments to the rules and have been given an opportunity to ask questions, comment and/or contribute to the proposed rules and all have urged adoption.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Department is not aware of any attorney general opinions or judicial rulings that directly relate to Chapter 1670-05-01.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

Recently released tourism data includes the following for 2014: The State of Tennessee has had 101.3 million person stays; tourism has provided 17.7 billion dollars in economic impact for Tennessee; and, there have been nine (9) consecutive years with more than one billion dollars (\$1,000,000,000) collected as a result of tourism in state and local taxes. This data does not incorporate a region by region breakdown of revenue collected as a result of tourism; however, there will be a probable increase in state and local government revenues and expenditures as a result of the promulgation of the rules. The rules will increase the maximum amount of State matching funds and the funding ratio from \$1.00 to \$2.00 in State matching funds for every \$1.00 of locally raised funds which regional tourism promotional organizations may apply for pursuant to T.C.A. Section 4-3-2207(b) and these revisions (also reflected in the underlying statute) may result in an increase in state and local revenue although the amount of such an increase cannot be determined from the data presently available to the Department.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Nancy Hargiss-Tatlock, General Counsel
Department of Tourist Development
312 Rosa L. Parks Ave., 13th Fl.
Nashville, TN 37243
Nancy.Hargiss-Tatlock@tn.gov
615-741-9065

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

John Carr, Assistant Commissioner of Administration; John.Carr@tn.gov; 615-741-9023
Nancy Hargiss-Tatlock, General Counsel; Nancy.Hargiss-Tatlock@tn.gov; 615-741-9065
Department of Tourist Development
312 Rosa L. Parks Ave., 13th Fl.
Nashville, TN 37243

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

John Carr, Assistant Commissioner of Administration; John.Carr@tn.gov; 615-741-9023
Nancy Hargiss-Tatlock, General Counsel; Nancy.Hargiss-Tatlock@tn.gov; 615-741-9065
Department of Tourist Development
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- (I) Any additional information relevant to the rule proposed for continuation that the committee requests.

The Department is unaware of any committee requests.

**Department of State
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For Department of State Use Only

Sequence Number: 06-03-16
Rule ID(s): 6192
File Date: 6/3/16
Effective Date: 9/1/16

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission: Tourist Development
Division: Administration
Contact Person: Nancy Hargiss-Tatlock
Address: William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, 13th Floor
Nashville, Tennessee
Zip: 37243
Phone: (615) 741-9065
Email: Nancy.Hargiss-Tatlock@tn.gov

Revision Type (check all that apply):

- Amendment
 New
 Repeal

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

Chapter Number	Chapter Title
1670-05-01	Guidelines for Organization Applying for Tourist Promotion Matching Funds
Rule Number	Rule Title
1670-05-01-.01	Purpose
1670-05-01-.02	Application and Certification
1670-05-01-.03	Requirements and Audit
1670-05-01-.04	Approval and Funds
1670-05-01-.05	Expenditure of Approved Funds
1670-05-01-.06	Repealed

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://sos.tn.gov/sites/default/files/forms/Rulemaking_Guidelines_August2014.pdf)

Chapter 1670-05-01-01
Guidelines for Organization Applying for Tourist Promotion Matching Funds

Amendments

Chapter 1670-05-01 Guidelines for Organization Applying for Tourist Promotion Matching Funds is amended by deleting it in its entirety and substituting instead the following:

Table of Contents

1670-05-01-01	Purpose	1670-05-01-04	Approval and Funds
1670-05-01-02	Application and Certification	1670-05-01-05	Expenditure of Approved Funds
1670-05-01-03	Requirements and Audit	1670-05-01-06	Repealed

1670-05-01-01 Purpose.

- (1) By the provisions set forth in ~~Section 11-605, Tennessee Code Annotated, Tennessee Code Annotated ("T.C.A.") § 4-3-2207, State Matching Funds~~ may be distributed to any regularly chartered, non-profit tourist promotion organization or tax exempt public agency promoting tourism throughout all the area within a planning region of the State of Tennessee as delineated by the [former] State Planning Commission and reiterated by Executive Order No. 17 issued by Governor Buford Ellington on October 14, 1968 (hereafter an "Organization").
- (2) It is further stated that each said Organization operating under the provisions of this chapter shall operate in complete accordance with ~~Section 11-605, Tennessee Code Annotated, T.C.A. § 4-3-2207,~~ and that funds appropriated to implement the provisions of this chapter are subject to the approval recommendation of the Commissioner of Tourist Development and approval of the Commissioner of Finance and Administration.
- (3) Pursuant to the above and in compliance with ~~Section 11-605, Tennessee Code Annotated, T.C.A. § 4-3-2207,~~ the following guidelines are hereby established, compliance with which is necessary for any Organization requesting certification for State Matching Funds.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206 and 4-5-201 et seq.

1670-05-01-02 Application and certification.

- (1) The applying Organization shall submit ~~annually,~~ with its initial application for State Matching Funds in a each fiscal year, a roster of its membership, together with the annual dues paid to the Organization and dues structure which shall act as certification that the applying Organization represents all the counties within its Planning Region ("Region") relative to the promotion of tourism. Annual dues paid for membership in the Organization or donations made to the Organization shall constitute acceptable matching local funds.
- (2) The applying Organization shall annually submit ~~annually~~ proof of its charter and non-profit status as either a non-profit corporation or tax exempt public agency.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206 and 4-5-201 et seq.

1670-05-01-.03 Requirements and audits.

- (1) The applying Organization is required to furnish the Department of Tourist Development with an annual report of its activities conducted by an independent public accountant registered with the Tennessee State Board of Accountancy for the prior State fiscal year (July 1- of the prior year through June 30 of each the present year). This report must be received by the Commissioner of Tourist Development before consideration will be given to approving said Organization for new fiscal year funding of State Matching Funds. Additionally, each applying Organization shall be audited subject to an audit annually by the Office of the Comptroller of the Treasury, State of Tennessee.
- (2) Bylaws of the applying Organization shall accompany the applying Organization's request for State Matching Funds, together with a roster of the Organization's Officers, Directors and Members of the Board showing representation from each county represented by the Organization. The Bylaws shall require that the applying Organization will operate under generally accepted good business practices. In addition, and include the following provisions the applying Organization must provide the following:
 - ~~(a) At least two (2) meetings of the Board of Directors of the organization will be held during a fiscal year with a quorum present. Minutes of said meetings shall be forwarded to the Department of Tourist Development;~~
 - (a) Signatures Documentation showing the signature of at least two (2) persons one (1) authorized person from said the Organization shall be required on all checks written on the Organization's account;
 - (b) Proof that Paid Executive(s) and other persons having access to the funds of said Organization must be are bonded at least to the amount of the State Matching Funds portion of its the Organization's annual budget; and
 - (c) Documentation of the dues structure of the Organization.
- ~~(3) Applying Organization shall be exempted from the provision requiring direct representation on its Board of Directors from each of the counties within its planning region if said Organization receives less than 25% (twenty-five percent) of its annual operating budget from matching funds monies; provided, however, said Organization submits to the Commissioner of the Department of Tourist Development a marketing plan established by a regional tourism committee showing the intended use of the state matching funds applied for. Said Organization shall establish a tourism committee made up of at least two representatives from each county within the Regional Development District for the purpose of establishing aforementioned marketing plan. This committee shall meet at least twice annually to review the marketing plan matching funds program, thereby evidencing participation of all of the counties within the Region.~~
- (3) The applying Organization shall submit, together with its application for State Matching Funds at the beginning of a fiscal year (July 1), a copy of its the Organization's marketing plan and total budget projections for the full fiscal year.
- (4) No application for State Matching Funds will be considered at the commencement of a fiscal year until an independent public accountant of Planning Regions' registered with the Tennessee State Board of Accountancy has furnished the Department of Tourist Development with an audit of the Planning Region's Organization's annual activities for the previous fiscal year and it has been received and reviewed by the Commissioner of the Department of Tourist Development and found to be in compliance with these guidelines and the intent of Section 11-605, Tennessee Code Annotated applicable provisions of the Tennessee Code Annotated.
- (5) The applying Organization must submit a letter, signed by its officers, stating full comprehension and intent that the Organization's officers fully comprehend and intend to adhere to these guidelines and applicable Sections of the Tennessee Code Annotated.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206 and 4-5-201 et seq.

1670-05-01-.04 Approval and funds.

- (1) The above mentioned documents must be sent to the Department of Tourist Development before any Organization can receive State Matching Funds monies. After review of the submitted documents by the Department of Tourist Development, the applying Organization will be notified of its eligibility to receive such the applied for State Matching Funds monies.
- (2) An approved Organization must forward to the Department of Tourist Development the following:
 - (a) The complete name and mailing address of the Organization;
 - (b) By Xerox, or another similar method, of copies of checks received from its the Organization's membership which it is using are being used as local matching money, copy along with copies of deposit slips showing such funds as actually being having been deposited into the Organization's account. Only those monies collected during the fiscal year for which the Organization is applying may be used as that Organization's matching money; and,
 - (c) Minutes of at least two (2) meetings of the Board of Directors of the Organization will be held during a fiscal year with a quorum present.
- (3) The Chief Executive Officer of an approved Organization shall meet with representative(s) of the Department of Tourist Development at least quarterly semi-annually during a fiscal year for the purpose of reviewing marketing goals of an approved Organization.
- (4) In order for the applying Organization to be eligible to retain up to the entire \$25,000.00 \$35,000.00 in State Matching Grant monies Funds, said Organization must, during the fiscal year, spend a total of \$50,000.00 (\$25,000.00 State monies, \$25,000 Region-raised funds) \$52,500.00 (\$35,000.00 of State Matching Funds, \$17,500.00 of Region-raised funds based on a ratio of \$2.00 of State Matching Funds for every \$1.00 of locally raised funds) on tourist promotion including administrative expenses which may include use of up to forty percent (40%) of State Matching Funds for administrative expenses in the Region. If the Organization should spend less does not have sufficient local matching funds to request up to than a total of \$50,000.00 \$35,000.00 within a fiscal year period, then the appropriate amount of State Matching monies Funds will be returned retained to by the Department of Tourist Development, at the end of the Fiscal year, which will, in turn, revert to the General Fund.
- (5) The final request for State Matching Funds in a fiscal year must be received by the Department of Tourist Development by no later than May 31 of that fiscal year.
- (6) Upon receipt of a completed application for State Matching Funds, said application will be forwarded to the Office of the Governor for approval by the Governor for approval by the Governor. The application shall then be sent to the Commission of Finance and Administration sent to the Commissioner of Tourist Development for recommendation and the Commissioner of Finance and Administration for approval and payment upon certification by the appropriate official of the applying Organization that Region-raised matching funds are available. State Matching Funds shall be distributed to the Organization on the basis of one dollar (\$1.00) two dollars (\$2.00) in State Matching Funds for each one dollar (\$1.00) contributed by the membership or through donations to the applying Organization up to a maximum of twenty-five thousand dollars (\$25,000.00) thirty-five thousand dollars (\$35,000.00) annually each fiscal year, according to the provisions of the law.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206, 4-3-2207 and 4-5-201 et seq.

1670-05-01-.05 Expenditure of approved funds.

- (1) The following provisions prevail as to use of State Matching Funds by an approved Organization and evidence required to show shall be considered evidence of that Organization's receipt of local matching contributions.

(a)

(2) All Organizations applying for and receiving State Matching Funds should maintain a separate Disbursement Journal pertaining to that portion of its budget funded by State Matching Funds. The following shall be adhered to as to expenditure of State Matching Funds monies:

- 1.(a) No more than forty percent (40%) of the total of State Matching Funds received in a fiscal year may be used for the administrative expense of operating said Organization. Administrative expenses includes: Salaries, in part or in total, of any employee, commissions, rent, machinery, office equipment, utilities, furnishings, taxes, payroll or otherwise, postage, insurance, telephone and other amenities generally considered essential in the day-to-day operation of a business.
- 2.(b) No State Matching Funds monies may be used to reimburse any member or contributor of said Organization for monies received which are used as locally raised Matching Funds, either by cash transaction, development of promotional materials for a contributor, or an in-kind services.
- 3.(c) Travel expenses to bona fide tourism travel/trade shows, exhibits, conventions, seminars, meetings, by authorized personnel representing the Organization are deemed to be eligible for the State's Matching Funds monies, provided attendance at such functions is in accordance with the Organization's marketing plan and the State's Travel Regulations.
- 4.(d) Expenditures for promotional material and events of the Organization's planning area, i.e., brochures of the Region, advertising through travel/trade press, billboards, new media, including radio, television, newspapers, periodicals, and other such outlets as are approved by the Commissioner of the Department of Tourist Development and outlined in the Organization's marketing plan.
- 5.(e) Sponsoring familiarization tours within the Planning Region to expose the area to travel/trade writers, travel agents, bus operators, tour brokers and wholesalers, airline personnel, and other groups capable of bringing visitors to the Region is are deemed an acceptable uses of State Matching Funds monies.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206, 4-3-2207. and 4-5-201 et seq.

1670-05-01-.06 Repealed.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206, 4-3-2207, and 4-5-201 et seq.

radio, television, newspapers, periodicals, and other such outlets as are approved by the Commissioner of the Department of Tourist Development and outlined in the Organization's marketing plan.

- (e) Sponsoring familiarization tours within the Region to expose the area to travel/trade writers, travel agents, bus operators, tour brokers and wholesalers, airline personnel, and other groups capable of bringing visitors to the Region are deemed acceptable uses of State Matching Funds.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206, 4-3-2207, and 4-5-201 et seq.

1670-05-01-.06 REPEALED.

Authority: T.C.A. §§ 4-3-2201 et seq., 4-3-2206, 4-3-2207, and 4-5-201 et seq.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Commissioner on 04/11/2016, and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 02/01/16

Rulemaking Hearing(s) Conducted on: (add more dates). 04/04/16

Date: April 13, 2016

Signature: [Handwritten Signature]

Name of Officer: Kevin R. Triplett

Title of Officer: Commissioner of Tourist Development

Subscribed and sworn to before me on: April 13, 2016

Notary Public Signature: [Handwritten Signature]

My commission expires on: My Commission Expires NOV. 6, 2017

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

[Handwritten Signature]

Herbert H. Slattery III
Attorney General and Reporter

6/1/2016

Date

Department of State Use Only

Filed with the Department of State on: 6/3/16

Effective on: 9/1/16



Tre Hargett
Secretary of State

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