

TennCare II Operational Protocol



**Bureau of TennCare
Nashville, Tennessee**

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Disclaimer

The purpose of the TennCare II Operational Protocol is to provide a general description of how the TennCare Demonstration functions. This is not an exhaustive discussion of the TennCare Demonstration, nor is it a legal document. It is a very basic overview of the Demonstration and a referral to other documents that provide more information about the TennCare program.

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Abbreviations & Acronyms

A & D	Alcohol and Drug
AAAD	Area Agency on Aging and Disability (sometimes referred to as a “Triple A-D”)
ACA	Affordable Care Act of 2010 (the Patient Protection and Affordable Care Act of 2010 (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010)
ACCENT	Automated Client Certification and Eligibility Network for Tennessee
ACLF	Assisted Care Living Facility
ADA	Americans with Disabilities Act
ADA-CDT	American Dental Association—Current Dental Terminology
ADL	Activity of Daily Living
AFDC	Aid to Families with Dependent Children
AHRQ	Agency of Healthcare Research & Quality (an agency within the U.S. DHHS)
ALA	Administrative Lead Agency
ALJ	Administrative Law Judge
AMA	American Medical Association
APN	Advanced Practice Nurse
AQS	Annual Quality Survey
ASH	Abortion, Sterilization, and Hysterectomy
ASO	Administrative Services Only
BBA	Balanced Budget Act of 1997
BDCHMI	Bad Debt, Charity, and Medically Indigent Costs
BPN	Best Practice Network
C & A	Child and Adolescent
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBER	Center for Business and Economic Research (University of Tennessee)
CBRA	Community-Based Residential Alternative [to Institutional Care]
CDC	Centers for Disease Control and Prevention
CEA	Cost Effective Alternative
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Plan (formerly referred to as SCHIP, i.e., the State Children’s Health Insurance Program)

CHR	Clinical Health Record
CM	Case Management or Case Manager
CMCS	Center for Medicaid and CHIP Services (under CMS)
CMHA	Community Mental Health Agency (case management)
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
COE	Center of Excellence
CON	Certificate of Need
CPE	Certified Public Expenditure
CPT	Current Procedural Terminology
CRA	Contractor Risk Agreement
CY	Calendar Year (January – December)
DBM	Dental Benefits Manager
DCS	[Tennessee] Department of Children’s Services
DESI	Drug Efficacy Study Implementation
DHHS	[United States] Department of Health & Human Services
DHS	[Tennessee] Department of Human Services
DIDD	[Tennessee] Department of Intellectual and Developmental Disabilities (formerly the Department of Intellectual Disability Services) ¹
DM	Disease Management
DMH	<i>See TDMH</i>
DOB	Date of Birth
DOH	[Tennessee] Department of Health
DSH	Disproportionate Share Hospital
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5 th Edition
D-SNIP	Dual Eligible Special Need Plan
DSP	Dental Screening Percentage
DUR	Drug Utilization Review
DY	Demonstration Year (July 1 – June 30)
EAH	Essential Access Hospital

¹ On January 15, 2011, responsibility for services regarding Developmental Disabilities was transferred from the Tennessee Department of Mental Health (TDMH) to the Tennessee Department of Intellectual and Developmental Disabilities (DIDD). DIDD's website, along with more information about developmental disabilities and services, can be accessed at <http://www.tn.gov/didd>.

EBP	Evidence-Based Practices
ED	Emergency Department
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMTALA	Emergency Medical Treatment and Active Labor Act
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
EVV	Electronic Visit Verification
F & A	[Tennessee] Department of Finance & Administration
FBDE	Full Benefit Dual Eligible
FEA	Fiscal Employer Agent
FERP	Federal Estate Recovery Program
FFM	Federally Facilitated Marketplace
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year (October 1 – September 30)
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
GHR	General Hospital Rate
GME	Graduate Medical Education
HCBS	Home and Community Based Services
HCFA	Health Care Finance and Administration (within the Tennessee Department of Finance and Administration)
HCFA	Health Care Financing Administration (predecessor to CMS)
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHA	Home Health Agency
HHS	<i>See DHHS</i>
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HRSA	[Federal] Health Resources & Services Administration
IADL	Instrumental Activity of Daily Living
ICD-9	International Classification of Diseases, 9 th Revision
ICF	Intermediate Care Facility

ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities (formerly known as Intermediate Care Facility for Persons with Mental Retardation, or ICF/MR)
ICF/MR	<i>See ICF/IID</i>
ID	Intellectual Disability
IEP	Individualized Education Plan
IHS	Indian Health Service
IMD	Institution for Mental Diseases
IME	Indirect Medical Education
IP	Inpatient
IRS	Identical, Related, or Similar (Drugs)
IRS	Internal Revenue Service
IS	Information Systems
KPI	Key Performance Indicator
LEA	Local Education Agency
LEP	Limited English Proficiency
LOC	Level of Care
LOS	Length of Stay or Length of Service
LSU	[TennCare] Legal Solutions Unit
LTE	Less Than Effective (Drugs)
LTSS	Long-term Services and Supports (formerly called Long-term Care)
MAGI	Modified Adjusted Gross Income
MCC	Managed Care Contractor
MCO	Managed Care Organization
MD	Medical Doctor
MDS	Minimum Data Set
MDSA	Medicare Disproportionate Share Adjustment
ME	Medically Eligible
MEG	Medicaid Eligibility Group
MEQC	Medicaid Eligibility Quality Control
MFCU	[Tennessee Bureau of Investigation (TBI)] Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
MNIS	Medically Needy Income Standard
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MR	Mental Retardation (Intellectual Disability, or ID, is generally preferred)

NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NP	Nurse Practitioner
OAA	Operational Administrative Agency
OBRA	Omnibus Reconciliation Budget Act
OGC	[TennCare] Office of General Counsel
OIG	Office of Inspector General
OIR	Office of Information Resources
OOP	Out-of-Pocket
OP	Outpatient
ORR	On Request Report
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
PAE	Pre-Admission Evaluation
PAHP	Prepaid Ambulatory Health Plan
PASRR	Pre-Admission Screening & Resident Review
PBM	Pharmacy Benefits Manager
PCCM	Primary Care Case Management
PCIP	Pre-Existing Condition Insurance Plan
PCP	Primary Care Provider
PDL	Preferred Drug List
PDN	Private Duty Nursing
PDP	[Medicare Part D] Prescription Drug Plan
PERS	Personal Emergency Response System
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PMPM	Per Member Per Month
PNA	Personal Needs Allowance
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act of 2010 (see ACA)
PPO	Preferred Provider Organization
PPS	Prospective Payment System
Pro-DUR	Prospective Drug Utilization Review

PSA	Public Service Announcement
QDWI	Qualified Disabled and Working Individuals
QHP	Qualified Health Plan
QIS	Quality Improvement Strategy
QIT	Qualifying Income Trust (as in Miller Trust)
QMB	Qualified Medicare Beneficiary
QMRP	Qualified Mental Retardation Professional
QO	Quality Oversight
RAC	Recovery Audit Contractor
Retro-DUR	Retrospective Drug Utilization Review
RFI	Request for Information
RFP	Request for Proposal
RMHI	Regional Mental Health Institute
RRU	Relative Resource Unit
RTF	Residential Treatment Facility (Unit)
SA	Substance Abuse
SAMHSA	[Federal] Substance Abuse & Mental Health Services Administration
SCHIP	<i>See CHIP</i>
SFY	State Fiscal Year (July 1 through June 30)
SLMB	Specified Low Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SNP	Special Needs Plan (Medicare)
SPA	State Plan Amendment
SPOE	Single Point of Entry
SSA	Social Security Administration or Single State Agency
SSD	Standard Spend Down
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSI FBR	Supplemental Security Income Federal Benefit Rate
STC	Special Term and Condition
TANF	Temporary Assistance for Needy Families
<i>T.C.A.</i>	<i>Tennessee Code Annotated</i>
TBI	Tennessee Bureau of Investigation
TBI	Traumatic Brain Injury
TCM	Targeted Case Management

TCM	TennCare Medicaid
TCMIS	TennCare Management Information System
TCS	TennCare Standard
TDCI	Tennessee Department of Commerce and Insurance
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services ²
TDOH	Tennessee Department of Health
TENNderCare	TennCare for Kids – EPSDT
TNCSA	Tennessee Community Services Agency
TNHC	Tennessee Health Connection
TRHCA	Tax Relief & Health Care Act of 2006
TPA	Third Party Administrator
TPL	Third Party Liability
TSU	TennCare Solutions Unit
UAT	User Acceptance Testing
UM	Utilization Management
VFD	Valid Factual Dispute
VSHP	Volunteer State Health Plan
YDC	Youth Development Center

² Effective January 15, 2011, with the transfer of Developmental Disabilities services to DIDD, TDMHDD changed its name to the Tennessee Department of Mental Health. Effective July 1, 2012, the Department changed its name to the Tennessee Department of Mental Health and Substance Abuse Services.

List of “User Friendly” Definitions

NOTE: For legal purposes, the definitions in the State rules and the State’s contracts are to be used.

State rules:

1200-13-01	TennCare Long-Term Care Programs
1200-13-13	TennCare Medicaid
1200-13-14	TennCare Standard
1200-13-16	Medical Necessity
1200-13-17	TennCare Crossover Payments for Medicare Deductibles & Coinsurance
1200-13-18	TennCare Administrative Actions and Provider Appeals

State MCO contract:

CRA	TennCare/MCO Contractor Risk Agreement (CRA) (Statewide)
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The following list is intended to provide “user friendly” program definitions for general reference only.

Activities of Daily Living (ADLs). ADLs are self-care activities which most people do on a daily basis, i.e., bathing, dressing and personal hygiene, toileting, transferring in and out of beds or chairs, ambulation (walking), and eating. The ability or inability to perform ADLs is often used as a measurement of a person’s functional status.

Adult Care Home. Under the CHOICES program, a state-licensed, community-based residential alternative to nursing facility care that offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-day basis is living in the home with the individuals for whom he is providing care. Coverage does not include the costs of Room & Board (see definition of Room & Board). Pursuant to State law, licensure is currently limited to Critical Adult Care Homes for persons who are ventilator-dependent or adults with traumatic brain injury (TBI).

Adult Day Care. Community-based group programs of care, provided under the CHOICES program to eligible members, lasting more than three (3) hours per day but less than twenty-four (24) hours per day. Adult Day Care is provided in an Adult Day Care facility pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

Affordable Care Act (ACA). The health care reform law enacted in March 2010, consisting of provisions from two pieces of legislation: the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA).

Applicant. A person who has applied for TennCare but whose application has not been approved or denied.

Area Agencies on Aging and Disability (AAAD). Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by *T.C.A.* Title 71, Chapter 2. Under CHOICES, the AAADs serve as the Single Point of Entry (SPOE) for individuals not currently enrolled in TennCare who are applying for long-term services and supports under the TennCare program. (See Single Point of Entry.)

Assets. See “Resources.”

Assisted Care Living Facility (ACLF). Community-based residential alternative to nursing facility care that provides and/or arranges for daily meals, personal care, homemaker and other supportive services, or health care including medication oversight (to the extent permitted under State law) in a home-like environment to persons who need assistance with activities of daily living. Coverage does not include the costs of room and board.

Assistive Technology. Assistive devices, adaptive aids, controls, or appliances, provided to CHOICES members, which enable an enrollee to increase his ability to perform activities of daily living or to perceive or control his environment. Examples include, but are not limited to, “grabbers” to pick objects off the floor, a strobe light to signify the smoke alarm has been activated, etc.

At Risk. The term “at risk” is used in various contexts and for various reasons by TennCare.

- “At risk” Managed Care Organization (MCO) – When an MCO is “at risk”, it is responsible for payment of all covered services needed by its members. The State pays the MCO a monthly fee for each enrollee assigned to its plan. (See Capitation Payment.)
- Children "at risk of State custody" – “Imminent risk of placement” into Department of Children’s Services (DCS) custody means circumstances or behavior likely to produce, within a relatively short period of time, a reasonably strong probability that the child will be placed in State custody as a result of being adjudicated dependent and neglected, delinquent, unruly or in need of mental health services under *T.C.A.* § 37-1-175.³
- Persons "at risk for institutionalization" – People who, without the availability of certain supports and services, will likely require placement in an institutional setting such as a Nursing Facility. In the context of the CHOICES program, being “at risk for institutionalization” is a prerequisite for enrollment in CHOICES Group 3 (including Interim CHOICES Group 3).

Attendant Care. Hands-on assistance, safety monitoring, and supervision for a CHOICES member who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visit. This care may include:

- Assistance with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and walking; and

³ *Tennessee Code Annotated (T.C.A.)* Section 37-3-602(3) (<http://www.lexisnexis.com/hottopics/tncode/>)

- Continuous safety monitoring and supervision during the period of service delivery.

In some circumstances, attendant care can also include certain homemaker services for CHOICES members who do not have a household member, relative, caregiver, or volunteer to provide them. These secondary types of hands-on assistance include picking up medications or shopping for groceries; meal preparation; and household tasks such as sweeping, mopping, dusting, changing linens, making the bed, washing dishes, doing laundry, ironing, and mending.

Attendant care does not include:

- Care or assistance, including meal preparation or household tasks, for other residents of the same household;
- Yard work; or
- Care of non-service related pets and animals.

Back-up Plan. A written plan specifying how a CHOICES member's needs will be met in situations when regularly scheduled HCBS providers are unavailable or do not arrive as scheduled. A back-up plan is a required component of the plan of care for all CHOICES members receiving companion care or non-residential HCBS in their own homes.

Call-in Line. This is the toll-free telephone number used as the single point of entry during an open enrollment period to accept new applications for Standard Spend Down.

Capitation Payment. The fee paid by the State to a managed care contractor operating under a risk-based contract for each enrollee covered by the plan for the provision of medical services. Capitation payments are made whether or not the enrollee uses services and without regard to the amount of services used during the payment period.

Caretaker Relative. A relative—by blood, adoption, or marriage—of a dependent child, under 19 years of age, with whom the child is living and who assumes primary responsibility for the child's care. The spouse of such a relative may also be considered a caretaker relative, even after the marriage is terminated by death or divorce. Caretaker relatives may be eligible for TennCare Medicaid if they meet the established income eligibility standards, or for TennCare Standard in the Standard Spend Down (SSD) category, if they meet the criteria for the category and the category is open for enrollment.

Case. A household unit that includes one or more persons who are TennCare-eligible.

Children's Health Insurance Program (CHIP; formerly known as SCHIP). CHIP is a program that offers coverage to low-income uninsured children. Tennessee's CHIP program is called "CoverKids." Uninsured TennCare Standard children with incomes at 211% of poverty and below are considered "CHIP children" in the TennCare II extension. Funding for services for "CHIP children" comes from Title XXI rather than Title XIX.

CHOICES (TennCare CHOICES in Long-term Services and Supports). A program that provides long-term services and supports benefits to enrollees meeting the CHOICES program criteria through the use of the provider network of TennCare managed care contractors (MCCs).

CHOICES 217-Like HCBS Group. Persons age 65 and older or adults age 21 and older with physical disabilities who: (1) meet the CHOICES NF level of care (LOC) requirement; (2) are receiving CHOICES HCBS; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 and Section 1924 of the Social Security Act, if the HCBS were provided under a 1915(c) waiver. (With the implementation of CHOICES, the Bureau no longer provides HCBS for the elderly and disabled under a 1915(c) waiver.)

CHOICES 1 and 2 Carryover Group. Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012 and who, upon redetermination of their eligibility on or after July 1, 2012, meet all the criteria for continuing in CHOICES 1 or CHOICES 2, except that they do not meet the LOC criteria that took effect on July 1, 2012. They must continue to meet the LOC criteria that were in effect on June 30, 2012, and must remain continuously enrolled in this group.

CHOICES At Risk Demonstration Group. Adults who are elderly or physically disabled; who meet the NF financial eligibility criteria; who meet the LOC criteria in effect as of June 30, 2012, but not the LOC criteria in effect as of July 1, 2012; and who, in the absence of CHOICES HCBS available through CHOICES 3, are at risk for institutionalization.

CHOICES Demonstration Group. Any of the following: the CHOICES 217-Like Group, the CHOICES At-Risk Demonstration Group, or the CHOICES 1 and 2 Carryover Group.

CHOICES Group 1. Individuals of any age who are receiving TennCare-reimbursed long-term services and supports in a Nursing Facility (NF).

CHOICES Group 2. Persons age 65 and older or adults age 21 and older with physical disabilities who meet the NF level of care (LOC) and who are receiving HCBS through the CHOICES program as an alternative to NF care. Members of CHOICES Group 2 qualify either as SSI recipients or as members of a Demonstration population such as the 217-Like Group or the CHOICES 1 and 2 Carryover Group,

CHOICES Group 3. Persons age 65 and older or adults age 21 and older with physical disabilities, who qualify for TennCare as SSI recipients and—while not meeting NF level of care (LOC) criteria—have been determined to be “at-risk” of Nursing Facility care. This category has never been open under CHOICES; however, see “Interim CHOICES Group 3.”

Closed Enrollment. A period of time during which a Demonstration category is not open for enrollment. (NOTE: Enrollment in Medicaid is always open.)

Community-based Residential Alternatives to Institutional Care (Community-based Residential Alternatives [CBRA]). Residential services, provided under the CHOICES program that offer a cost-effective, community-based alternative to nursing facility care. To qualify for CBRA services, a member must be elderly and/or an adult with a physical disability, and must meet nursing facility level of care criteria. CBRA services include, but are not limited to, assisted care living facilities, adult care homes, and companion care.

Companion Care. Under the CHOICES program, a consumer-directed residential model in which a CHOICES member, utilizing the services of a fiscal intermediary, may choose to select, employ, supervise, and pay on a monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance, or continuous supervision and monitoring, throughout the entire period of service duration. Companion care is available only for a CHOICES member who requires, and does not have available through family or other caregiver supports, frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services.

Consumer Assessment of Healthcare Providers and Systems (CAHPS). A set of standardized surveys that measure patient satisfaction with the experience of receiving care. CAHPS is sponsored by the Agency for Healthcare Research and Quality (AHRQ).

Consumer Direction of Eligible Home and Community Based Services. Under the CHOICES program, the opportunity for a member assessed to need specified types of HCBS to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services – primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers in delivering the needed service(s). The HCBS eligible for consumer direction are attendant care, personal care visits, in-home respite care, and companion care.

Consumer-Directed Worker (Worker). An individual who has been hired by a CHOICES member participating in consumer direction of HCBS or his representative to provide one or more eligible HCBS to the member. "Worker" does not include an employee of an agency being paid by an MCO to provide HCBS to the member.

Contractor Risk Agreement (CRA). The document that describes the terms of agreement entered into by the Bureau of TennCare and a managed care contractor.

Cost-effective Alternative (CEA) Service. A service that is not a covered service but that is approved by TennCare and may be provided at the MCO's discretion. There is no entitlement to receive this service. CEA services may be provided because they are:

- Alternatives to covered Medicaid services that, in the MCO's judgment, are cost-effective; or
- Preventive in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

A CEA service need not be determined medically necessary, except to the extent that it is provided as an alternative to covered Medicaid services. Even if medically necessary, CEA services are not covered services and are provided only at the MCO's discretion.

For purposes of CHOICES, CEA services may include the provision of HCBS as an alternative to NF care when the enrollment target for CHOICES Group 2 has been reached, as described in Rule 1200-13-01-.05.

Cost Neutrality Cap. The requirement that the cost of providing care to a member in CHOICES Group 2, including HCBS, home health, and private duty nursing, may not exceed the cost of providing nursing facility services to the member.

Covered Services. Those health care services -- medical, mental health and substance abuse, dental, and pharmacy -- listed in TennCare Medicaid rules 1200-13-13-.04 and TennCare Standard rules 1200-13-14-.04 as being available to TennCare program enrollees through their managed care contractors. Additional long-term services and supports are available through the TennCare CHOICES program and the TennCare waiver programs for individuals with intellectual disabilities. Covered long-term services and supports are described in rule 1200-13-01. CHOICES services, which are available to persons who qualify for and are enrolled in the CHOICES program, are described in the Bureau's rules at 1200-13-01-.05.

Demonstration Eligible. A person who is not eligible under Tennessee's State Plan (TennCare Medicaid) but who is otherwise eligible for the TennCare Demonstration project. Demonstration eligibles are enrolled in TennCare Standard.

Demonstration Project. A project approved by the Centers for Medicare and Medicaid Services (CMS) that allows certain Medicaid statutes and regulations to be waived for the purpose of "demonstrating" or testing a principle or set of principles about health care. The TennCare program is a Demonstration Project designed to show that use of a managed care approach can enable the State to deliver quality care to enrollees without spending more than if the State had continued its Medicaid program.

Dental Benefits Manager (DBM). A contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare program to the extent that such services are covered by TennCare.

Disenrollment. This term is used in various ways in the TennCare program. 42 CFR § 438.56 uses the term "disenrollment" to refer to the process by which individuals change MCOs. The TennCare program has historically used the term "disenrollment" to refer to the process by which a person who has lost eligibility for TennCare benefits is removed from the program, as described in STC Section XIII, Part 1. Disenrollment may be voluntary or involuntary, e.g., a CHOICES member may be disenrolled from CHOICES HCBS by TennCare when his needs can no longer be adequately met in the community. Proper interpretation of the term "disenrollment" depends upon the context in which it is used.

Dual Eligible. An individual who is eligible for both Medicare and TennCare, or who qualifies for TennCare assistance with his Medicare cost sharing.

- A Full Benefit Dual Eligible is a person who is entitled to Medicare Part A and/or Part B and full Medicaid benefits under TennCare. He gets most of his services from Medicare, and he also gets the services TennCare covers that Medicare does not cover. Two examples of services that TennCare covers but Medicare does not are non-emergency transportation and mental health case management.

- A Partial Benefit Dual Eligible is a Medicare beneficiary who does not qualify for TennCare, but who qualifies for TennCare to pay some or all of his Medicare cost-sharing expenses.

Electronic Visit Verification (EVV) System. An electronic system in which CHOICES caregivers can check in at the beginning and check out at the end of each period of service delivery. The system monitors the member's receipt of HCBS and is also used to generate claims for submission by providers.

Eligible. A person who has been determined eligible for the TennCare program. As it relates to CHOICES, a person is eligible to receive CHOICES benefits only if he has been enrolled in CHOICES by TennCare.

Enrollee. A person who has been determined eligible for the TennCare program and who has been enrolled in the program.

Federal Estate Recovery Program (FERP). A program set forth under Section 1917(b) of the Social Security Act that requires states offering Medicaid-reimbursed long-term services and supports to seek adjustment or recovery as follows:

- For persons age 55 or older, the State is obligated to seek adjustment or recovery for Nursing Facility (including ICF/IID) services, HCBS, and related hospital and prescription drug services.
- For permanently institutionalized persons under age 55, the State is obligated to seek adjustment or recovery for the institutional services.

Federally-Facilitated Marketplace (FFM) (also known as the Exchange). As required by the Affordable Care Act (ACA), a system established and operated by the Secretary of Health and Human Services (HHS) for consumers in states that elect not to operate a State-based Marketplace (SBM) to enroll in health coverage. The FFM has the capacity to enroll applicants into "Insurance Affordability Programs," which include subsidized health insurance offered through Qualified Health Plans (QHPs), most Medicaid categories, and CHIP.

Fiscal Employer Agent (FEA). An entity contracting with the State and/or an MCO that provides financial administrative services and supports brokerage functions (see Supports Broker) to CHOICES members participating in consumer direction of HCBS.

Fraud. An intentional deception or misrepresentation made by a person who knows, or should have known, that the deception could result in an unauthorized benefit to himself or another person, including any act that constitutes fraud under applicable federal or state law.

Full Benefit Dual Eligible (FBDE). A Medicare beneficiary who is also eligible for the TennCare program. See also "Dual Eligible."

Health Maintenance Organization (HMO). An entity licensed by the Tennessee Department of Commerce and Insurance, under applicable provisions of *Tennessee Code Annotated (T.C.A.)* Title 56, Chapter 32, to provide health care services.

Health Plan. A managed care organization (MCO) contracted with the Tennessee Department of Finance and Administration to pay for and/or coordinate medical, behavioral, and long-term services and supports for enrollees in the TennCare program.

Healthcare Effectiveness Data and Information Set (HEDIS). The most widely used set of performance measures in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).

Home and Community Based Services (HCBS). Services that are provided in a home or community setting as an alternative to (or to delay the need for) long-term care services in a Nursing Facility (NF) or an Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID). Under CHOICES, HCBS are available to members qualifying for, and enrolled in, CHOICES.

Home-delivered Meals. Under the CHOICES program, nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the enrollee’s home. Special diets are provided in accordance with the individual Plan of Care when ordered by the enrollee’s physician.

Homemaker Services. Under the CHOICES program, general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member’s linens, making the member’s bed, washing the member’s dishes, doing the member’s personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of a safe environment, and errands such as grocery shopping and having the member’s prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member. Homemaker services are provided only as part of Personal Care Visits and Attendant Care services for members who also require hands-on assistance with activities of daily living (ADLs).

Household. Eligibility for TennCare Medicaid in a Modified Adjusted Gross Income (MAGI) category is based on an income threshold, relative to the number of individuals in a household. The number of individuals considered members of the household when determining eligibility is based on tax filer rules for individuals who file a tax return and are not claimed as a dependent by another taxpayer; for individuals who file a tax return and are not claimed as a dependent by another tax payer; and for individuals who neither file a tax return nor are claimed as a dependent.

Immediate Eligibility. A process by which children entering state custody (other than those going into Youth Development Centers [YDCs]) and who are not already TennCare-eligible are assigned to TennCare Select so they can immediately start receiving TennCare-reimbursed health care services while their eligibility is being determined. If the eligibility determination process results in the child’s not being eligible for the TennCare program, DCS will refund to TennCare Select any payments made on the child’s behalf.

Income. Monies received such as salaries, wages, pensions, certain rental income, interest income, dividends, royalties, etc., which produce a gain or a benefit to the recipient. “Income” is distinguished from “resources.” See definition of “Resources.”

In-home Respite Care. Services provided under the CHOICES program to members unable to care for themselves, furnished on a short-term basis in the member’s place of residence, because of the absence or need for relief of those persons normally providing the care.

Inpatient Respite Care. Services provided under the CHOICES program to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

Instrumental Activities of Daily Living (IADLs). IADLs are not necessary for fundamental functioning (see ADLs), but allow an individual to live independently in the community. Functions classified as IADLs include meal preparation, light housekeeping, laundering of soiled bed linens or bedclothes, grocery shopping, use of the telephone, taking medications, financial management, and the ability to drive or use public transportation.

Insurance Affordability Program. Any one of three programs: Subsidized coverage through the Marketplace, Medicaid, or CHIP.

Interim CHOICES Group 3. A CHOICES eligibility group that is open to enrollment only between July 1, 2012, and June 30, 2015. The group includes persons who are enrolled in CHOICES because they have been determined to meet the LOC criteria in effect on June 30, 2012, as well as all other CHOICES eligibility criteria.

Managed Care Contractor (MCC). A managed care organization (MCO) that has signed a TennCare Contractor Risk Agreement (CRA) with the State, operates a provider network, and provides covered health services to TennCare enrollees.

An MCC can also be a State government agency (i.e., the Department of Children’s Services and the Department of Intellectual and Developmental Disabilities) that contracts with TennCare for the provision of services.

The Pharmacy Benefits Manager (PBM) and Dental Benefits Manager (DBM) are also considered to be MCCs. However, they are classified as Prepaid Ambulatory Health Plans (PAHPs), and their contracts are not “at full risk” as are those for MCOs.

Managed Care Organization (MCO). An appropriately licensed Health Maintenance Organization (HMO) under contract with the Bureau of TennCare.

Marketing. The Bureau of TennCare uses the term “marketing” to refer to all contacts made by managed care entities with enrollees, including letters, enrollee satisfaction surveys, newsletters, etc.

Medicaid. The program for medical assistance provided under Title XIX of the Social Security Act for certain persons with low incomes and/or special circumstances. Medicaid programs are administered jointly by the State and the Federal government. The parameters under which the Bureau operates Tennessee’s Medicaid program are found in the Medicaid State Plan and the TennCare 1115 Demonstration Waiver.

Medicaid eligible. A person who is eligible under the Tennessee Medicaid State Plan (otherwise known as “TennCare Medicaid”). Eligibility for TennCare Medicaid is determined by either the Social Security Administration (SSA), the Federally Facilitated Marketplace (FFM) (for MAGI eligibility categories), and the Bureau of TennCare (for non-MAGI categories). The Tennessee Department of Health (DOH) determines presumptive eligibility under TennCare Medicaid for pregnant women and for women diagnosed with breast or cervical cancer who are eligible for the Breast and Cervical Cancer Screening Program. However, presumptively eligible persons must still complete the application process with the FFM within specified timeframes in order to continue eligibility.

Medicaid Rollover. A person who is allowed to “roll over” from TennCare Medicaid to TennCare Standard. A TennCare Medicaid enrollee who no longer meets technical eligibility requirements for Medicaid and who is under the age of 19 may be allowed to roll over to TennCare Standard, in accordance with the provisions of TennCare Rule 1200-13-14-.02. To roll over, an individual must be under age 19, lack access to insurance, and have income 211% of poverty and below OR have income above 211% and be determined “Medically Eligible”. Medicaid Rollovers must complete their applications within specified time periods.

Medically Eligible. An uninsured person under age 19 who is not Medicaid-eligible, and who qualifies for TennCare Standard based on certain medical conditions.

Medically Necessary. A medical item or service that meets the criteria described in *T.C.A. § 71-5-144* and applies to TennCare program enrollees. An enrollee is not entitled to receive, and the TennCare program shall not be required to pay for, any items or services that do not satisfy all criteria of “medically necessary”, as defined in the statute or in the Medical Necessity rule chapter at 1200-13-16.

Medically Needy. A Medicaid eligibility category described in Section 1902(a)(10)(C) of the Social Security Act. The Medically Needy category in Tennessee is limited to pregnant women and children under age 21.

Medicare. The program for medical assistance, provided under Title XVIII of the Social Security Act, for elderly and certain disabled individuals. The Medicare program is administered solely by the federal government.

Minor Home Modification. Under the CHOICES program, the provision and installation of certain home mobility aids (e.g., wheelchair ramps and modifications directly related to and specifically required for the construction or installation of the ramps, hand rails for interior or exterior stairs or steps, grab bars, and other devices) and minor physical adaptations to the interior of a member’s place of residence that are necessary to ensure the health, welfare, and safety of the individual, or which increase the member’s mobility and accessibility within the

residence, such as widening of doorways or modification of bathroom facilities. Exceptions are listed in TennCare rule 1200-13-01-.02 and in Attachment D of the TennCare II Waiver.

Modified Adjusted Gross Income (MAGI). The new method, required by the ACA, for calculating income eligibility for Medicaid, CHIP, and financial assistance available through the health insurance Marketplace. In the past, Medicaid and CHIP eligibility used a combination of an income eligibility standard—often expressed as a percentage of the FPL—and a series of deductions (known as “disregards”) to income and were determined by each state. MAGI translates that two-part process into a single step that incorporates the disregards, making the new standard appear higher than the previous one (e.g. from 185% of the FPL to 193% of the FPL for pregnant women). The MAGI-based standard is intended to result in approximately the same number of people being eligible as under the previous standard.

National Committee for Quality Assurance (NCQA). A nonprofit organization committed to assessing, reporting on, and improving the quality of care provided by organized delivery systems. Useful information on NCQA may be accessed at the NCQA website: www.ncqa.org.

Nursing Facility (NF) Care. Nursing care provided under the CHOICES program in a facility that meets the NF requirements found at 42 U.S.C. § 1396r. There are two levels of NF care in Tennessee. Level 1 is a less intensive level of care than Level 2. NFs must be licensed and certified by the Tennessee Department of Health.

Open Enrollment. A period of time announced by the State during which enrollment in an identified Demonstration category is open and applications for that category are accepted.

PACE Carryover Group. A group of persons who were enrolled in PACE on June 30, 2012, and who, upon their next redetermination of eligibility on or after July 1, 2012, are found to meet all PACE criteria except the new LOC criteria that went into effect on July 1, 2012. Persons in this group must continue to meet the LOC criteria in place on June 30, 2012 to remain enrolled.

Partial Benefit Dual Eligible. A Medicare beneficiary who is not eligible for TennCare but who, because of his income, is eligible for TennCare to pay some, or all, of his Medicare cost-sharing. See also “Dual Eligible.”

Personal Care Visits. Intermittent visits of limited duration, under the CHOICES program, not to exceed four (4) hours per visit and two (2) visits per day, at intervals of no less than four (4) hours between visits, to provide hands-on assistance to a member who, due to age and/or physical disability, needs help with ADLs (see Activities of Daily Living). Personal care visits do not include:

- Companion or sitter services, including safety monitoring and supervision;
- Care or assistance, including meal preparation or household tasks, for other residents of the same household;
- Yard work; or
- Care of non-service related pets and animals.

Personal Emergency Response System (PERS). An electronic device, provided to certain individuals enrolled in the CHOICES program and receiving HCBS, which enables them to summon help in an emergency. The individual may also wear a portable ‘help’ button to allow for mobility. The system is programmed to signal a response center once the ‘help’ button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to use such system effectively and who live alone, or who are alone with no caregiver for extended periods of time, such that the individual’s safety would be compromised without access to a PERS.

Pest Control. A service provided under the CHOICES program involving the use of sprays, poisons and traps, as appropriate, in the member’s residence (excluding NFs or ACLFs) to regulate or eliminate the intrusion of roaches, wasps, mice, rats, and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail, elderly or disabled member’s health and physical well-being.

Pharmacy Benefits Manager (PBM). An organization under contract with the Tennessee Department of Finance and Administration to pay for and/or coordinate pharmacy benefits for enrollees to the extent such services are covered by the TennCare Program. A PBM may have signed a TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO.

Plain Language. The reading level of notices, letters, explanations, or other written material sent by TennCare, it’s MCCs, or other contractors to TennCare enrollees and applicants. Language used in such materials must not exceed a sixth grade reading level, as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

Poverty Level (also known as the Federal Poverty Level [FPL]) Guidelines. Guidelines for determining poverty-level income issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). These guidelines are generally published in January or February and are used for administrative purposes — for instance, in determining financial eligibility for Medicaid and other federal programs.⁴

Pre-admission Evaluation (PAE). A document providing an assessment of an individual’s functioning level that is used to determine medical eligibility for LTSS.

Pre-admission Screening & Resident Review (PASRR). A federal requirement to help ensure that persons having needs for specialized mental health or intellectual disability services are not placed inappropriately in nursing facilities.

Prepaid Ambulatory Health Plan (PAHP). A health plan that provides less than comprehensive services on an at-risk, or other than State Plan, reimbursement basis and does not provide,

⁴ The 2014 Poverty Guidelines can be found at the following website:
<http://aspe.hhs.gov/poverty/14poverty.cfm>

arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. There are several types of PAHPs that states use to deliver a range of services. For example, a dental PAHP is a managed care entity that provides only dental services.

Prepaid Inpatient Health Plan (PIHP). A health plan that provides less than comprehensive services on an at-risk, or other than State Plan, reimbursement basis and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. There are several types of PIHPs that states use to deliver a range of services. For example, a Mental Health (MH) PIHP is a managed care entity that provides only mental health services.

Presumptive Eligibility. An established period of time during which certain individuals—such as, pregnant women and women identified by the Centers for Disease Control and Prevention (CDC) as being uninsured or underinsured and needing treatment for breast or cervical cancer—are eligible for Medicaid. During this period of time, the presumptively eligible person must complete an application and qualify for Medicaid in order to stay on the program.

Program Integrity. Proper TennCare program management that ensures high-quality, efficient care and appropriate use of funds, with minimal waste. Program integrity initiatives work to prevent and detect waste, fraud, and abuse; to increase program transparency and accountability; and to recover improperly used funds.⁵

Redetermination. The annual process that occurs for all TennCare Medicaid and Standard enrollees during which they must provide documentation that they continue to meet the eligibility requirements for continued enrollment in the TennCare program.

Reduction, Suspension, or Termination of Benefits. The acts or omissions by TennCare, or others acting on its behalf (e.g., MCCs, other State agencies under contract with TennCare), which interrupt a course of necessary clinical treatment for a continuing period of time or medical condition.

Renewal. A term that has the same meaning as “Redetermination.”

Reserve Capacity. Under the CHOICES program, the State’s right to maintain some open slots within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent; or other circumstances which the State may establish from time to time in accordance with the STCs of the TennCare II Waiver.

Resources. Assets such as savings accounts, personal property, etc., which are available to an individual and are considered when determining an individual’s eligibility for certain TennCare categories. Resources are not counted for individuals who are TennCare Medicaid-eligible based on MAGI-income standards or for Uninsured children in the Demonstration population. For

⁵ See *Program Integrity in Medicaid: A Primer*, available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8337.pdf>.

enrollees in the TennCare Standard Spend Down (SSD) population, resources are counted in accordance with the criteria that apply to Medically Needy pregnant women and children under the State Plan. Resources are also taken into consideration for those applying for the CHOICES 217-Like HCBS Group.

Retroactive Eligibility. Eligibility which begins as of a date in the past. TennCare eligibility is effective on the date of application, if the applicant is subsequently approved, or the date of a qualifying event (such as the date that spend down requirements are met), whichever is later. TennCare Medicaid eligibles do not get automatic periods of retroactive eligibility as Medicaid eligibles do in other states. This regulation was “waived” for the TennCare Demonstration project, since it is difficult to manage care for people whose enrollment date is prior to their enrollment into a managed care plan. An additional rationale for waiving retroactive eligibility is to encourage people to sign up for care at the earliest opportunity, rather than waiting and assuming that all expenses in the past will be covered.

Room and Board. Lodging, meals, and utilities. Such items, which are not reimbursable by TennCare, include:

- Rent, or if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident “raw” food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable or pay television

Short-Term Nursing Facility (NF) Care. The provision of NF care for no more than 90 days to a CHOICES member who was receiving home and community-based services (HCBS) upon admission and who requires temporary placement in a NF – for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver – when such member is reasonably expected to be discharged and to resume HCBS participation within 90 days.

Single Point of Entry (SPOE). The entity (i.e. the Bureau of TennCare, or its designee) responsible for screening individuals wishing to enroll in the CHOICES program, using the tools and protocols specified by the Bureau to make such determinations. Such screening processes assess:

- (1) Whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES;
- (2) Whether the applicant appears to meet NF level of care; and

- (3) For an applicant seeking access to HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed NF care.

Note: Area Agencies on Aging and Disability serve as the Single Point of Entry for the CHOICES program. Only CHOICES applicants who are not already enrolled in TennCare require an interface with the SPOE.

Special Terms and Conditions (STCs). The provisions approved by CMS and agreed to by the Bureau, which govern the operation of the TennCare Demonstration project.

Spend Down. A term associated with the Medically Needy program, which is an optional eligibility category that states may choose to cover in their Medicaid programs. (See 42 CFR 435, Subpart D.) To “spend down” means that one has a sufficient amount of unreimbursed medical bills to reduce his monthly income to the state's Medically Needy Income Standard (MNIS). TennCare Medicaid's Medically Needy program covers pregnant women and children to age 21.

Standard Spend Down (SSD). An eligibility category in TennCare Standard. Standard Spend Down enrollees are defined as non-pregnant adults, aged 21 and older who are aged, blind, disabled, or caretaker relatives of Medicaid-eligible children, and who have met spend down criteria patterned after the criteria used in the TennCare Medicaid Medically Needy program.

State Plan. A Medicaid State Plan (Plan) outlines the design of each state's Medicaid program to the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid. Once CMS approves the original Plan, they must also approve all future changes (State Plan Amendments) to the Plan before any changes become effective.

Supplemental Security Income (SSI). A cash benefit program for low-income aged, blind, and disabled individuals administered by the Social Security Administration (SSA) for those meeting program eligibility requirements. In Tennessee, residents determined to be eligible for SSI benefits are automatically enrolled in TennCare Medicaid.

Supports Broker. Under CHOICES Consumer Direction, an individual assigned by the Fiscal Employer Agent (FEA) who assists the member (or his representative) in performing the employer of record functions, including, but not limited to, developing job descriptions and locating, recruiting, interviewing, scheduling, monitoring, and evaluating workers. The Supports Broker works with the member's MCO-assigned care coordinator. The Supports Broker does not have authority or responsibility for Consumer Direction.

Each enrollee who selects participant management in an HCBS ID Waiver has an individual budget and access to an independent Supports Broker, which functions similarly to the Supports Broker in the CHOICES program.

TennCare CHOICES in Long-Term Services and Supports (CHOICES). *See CHOICES.*

TennCare I. The TennCare program that existed between 1994 and 2002.

TennCare II. The TennCare program that has been in existence since 2002.

Third Party Administrator (TPA). Non-risk-bearing administrator of, or claims processor for, health plans. In the TennCare program, the Dental Benefits Manager (DBM) and the Pharmacy Benefits Manager (PBM) are licensed as TPAs. The TennCare program carries the risk of loss for claims rather than the DBM or PBM.

Transition Allowance. Under the CHOICES program, this is a per-member allowance that may not exceed \$2,000 per lifetime used to facilitate transition from an NF to a community setting. The provision of this allowance is at the sole discretion of the MCO and is provided as a cost-effective alternative to continued institutional care.

Transitional Medicaid. The availability of continuing Medicaid coverage for a period after an individual receives earnings that would make them ineligible for regular Medicaid.

Uninsured. A person who does not have health care coverage through an individual or group insurance plan..

Valid Factual Dispute. A controversy that, if resolved in favor of the enrollee, would prevent the State from taking the action that is the subject of the controversy. For example, the question of whether provision of a *covered* service is “medically necessary” raises a valid factual dispute. In contrast, the question of whether provision of an *excluded* service is “medically necessary” fails to comprise a valid factual dispute. Thus, a coverage dispute involving a prescribed bariatric surgery raises a valid factual dispute, the resolution of which depends on whether or not the surgery is “medically necessary” pursuant to TennCare rule. By contrast, a coverage dispute involving a prescribed hair transplant procedure does not raise a valid factual dispute because the procedure is excluded from coverage under TennCare rules.

Waiver. See Demonstration Project.

Understanding TennCare Program Terms

TennCare is the name for the State's Section 1115 Managed Care Demonstration. TennCare I was the TennCare program that existed between 1994 and 2002. TennCare II is the TennCare program that has been in existence since 2002.

TennCare Medicaid is the name of the portion of the TennCare program that is composed of Medicaid-eligible individuals.

TennCare Standard is the name of the portion of the TennCare program that includes individuals who are not eligible for Medicaid. Persons in TennCare Standard must be members of a Demonstration population, which is a population approved by CMS for inclusion in TennCare. There are currently seven Demonstration populations in TennCare Standard. These populations are identified in Chapter 2 of the Operational Protocol.

TennCare Select is the name of the State's self-insured managed care plan that is administered by a contractor to handle certain populations and to be available in any area where there is inadequate MCO capacity. TennCare Select is also intended to serve as a back-up if one of the other managed care plans leaves the project unexpectedly.

TennCare CHOICES is the program that provides long-term services and supports through TennCare's managed care delivery system. The purpose of CHOICES is to demonstrate that long-term services and supports can be offered within the context of a managed care environment and that the resulting savings can fund more options for people who are elderly or disabled and who would otherwise require Nursing Facility care. These options would allow eligible individuals to remain in their homes and communities rather than having to enter Nursing Facilities.

Chapter 1:

Overview



TennCare II Operational Protocol

Section 1.1

TennCare as a Medicaid “Demonstration” Project

TennCare is a Medicaid “Demonstration” Project.

“Medicaid” is a program jointly funded by the state and federal governments to provide certain defined healthcare benefits to persons meeting specified eligibility criteria. Every state has a Medicaid program. The federal agency with responsibility for overseeing the Medicaid program is the Centers for Medicare and Medicaid Services (CMS), located in the U.S. Department of Health and Human Services.

Medicaid is not the same as *Medicare*. Medicare is a federal program for persons who are age 65 and older, as well as certain younger people who meet specified criteria. The State has no oversight over the Medicare program. Although Medicare and Medicaid are different programs, it is possible for people to be eligible for both programs. A person who is eligible for both Medicare and Medicaid is called a “dual eligible.”

TennCare is basically a Medicaid program, designed to provide Medicaid benefits to Medicaid-eligible enrollees; however, it differs from other state Medicaid programs in that it operates under certain “waivers” of federal regulations to “demonstrate” a specific health care premise. The goal of the TennCare Demonstration is to show that use of a managed care approach can enable the State to deliver quality care to all enrollees without spending more than if the State had continued its Medicaid program. Many states operate Medicaid demonstration programs, but each is unique in its structure and the populations it serves.

TennCare is called an “1115 waiver” because it is authorized under Section 1115 of the Social Security Act. There are other waivers authorized under the Social Security Act—most importantly, Home and Community Based Services (HCBS) waivers operated under Section 1915. However, the 1115 waiver is the only waiver that a state can use to extend Medicaid eligibility to persons who would otherwise be ineligible.

Both 1115 and 1915 waivers are time-limited and must be renewed, or extended, at regular intervals. “TennCare I” was the original TennCare waiver that began on January 1, 1994, and continued, with various extensions, through June 30, 2002. “TennCare II” is the waiver that began on July 1, 2002. The TennCare II waiver has been extended three times by CMS and is currently in effect through June 30, 2016.

In March 2010, TennCare began implementation of an important new component of TennCare II called TennCare CHOICES in Long-Term Services and Supports (CHOICES). The program was developed as a result of the passage of the Long-Term Care Community Choices Act of 2008 by the Tennessee General Assembly. The purpose of CHOICES is to demonstrate that long-term services and supports can be offered within the context of a managed care environment and can result in more options for people who are elderly or disabled, and would otherwise require nursing facility care. These options allow eligible individuals to remain in their homes and communities, while reserving nursing facility services for people with the most severe needs. The CHOICES program was implemented in Middle Tennessee on March 1, 2010 and in East and

West Tennessee beginning August 1, 2010. Under CHOICES, eligible TennCare program enrollees receive long-term services and supports (i.e. nursing facility services or certain home and community-based services) through their Managed Care Organizations (MCOs).

Section 1.2 Purpose of the Operational Protocol

The Operational Protocol is intended to provide a brief overview of the TennCare program and a quick reference to its criteria, such as TennCare benefits, eligibility categories, etc.

It is important to recognize that there are a number of legal documents that govern the TennCare program, including:

- TennCare Demonstration approval materials, specifically the Special Terms and Conditions (STCs), the Expenditure Authorities, and the Waiver List. These materials are available online at <http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf>. Attachment H to the Operational Protocol contains a table of the STCs that currently guide the Bureau in the operation of the TennCare waiver. The STCs represent an agreement between CMS and the State on how the TennCare program should function. The STCs may be revised as the result of an amendment to the waiver, or during the waiver renewal.
- The Tennessee Medicaid State Plan, which is required of every state operating a Medicaid program. This document is available online at <http://www.tn.gov/tenncare/pol-stateplan.html>.
- TennCare rules, which are filed with the Tennessee Secretary of State's office. The rules for TennCare Medicaid, TennCare Standard, and TennCare Long-Term Care Programs are available online at <http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm>.
- A list of significant court cases affecting TennCare programs and services may be viewed online at <http://www.tn.gov/tenncare/legal.html>.

While they are not legal documents, TennCare Policy Statements—which are prepared by the Bureau of TennCare and posted on the TennCare website—provide additional information on certain topics of interest. These may be viewed at the following site: <http://www.tn.gov/tenncare/pol-policies.html>.

The TennCare website, <http://www.tn.gov/tenncare/>, contains a wealth of information about the TennCare program.

The above citations will be repeated throughout this Operational Protocol to assist the reader in finding additional resources.

Section 1.3 Organization and Structure of the Demonstration

The TennCare Demonstration is administered by the Bureau of TennCare (Bureau), which is part of the Division of Health Care Finance and Administration within the Tennessee Department of Finance and Administration. The Department of Finance and Administration oversees all State spending, and the Commissioner of the Department serves as Chief Financial Officer to the Governor.

The Bureau is headed by a Deputy Commissioner and includes the following divisions:

- Office of the Chief Medical Officer
- Operations
- Member Services
- Managed Care Operations
- Fiscal Operations
- Information Systems
- Policy Office
- Office of General Counsel
- Long-Term Services and Supports
- Office of Communications
- Non-discrimination Compliance and Health Care Disparities

An abbreviated organizational chart for the Bureau can be found in Attachment A.

Special Term and Condition (STC) #14 states that the Bureau will assure the adequacy of its infrastructure to implement and monitor the Demonstration.

Other State departments administer portions of the TennCare Demonstration, under the direction of the Single State Agency (the Department of Finance and Administration). These State departments, and their TennCare-related functions, are shown in Table 1-1.

Table 1-1: State Agencies Involved in the TennCare Demonstration

Agency	Functions
Office of the Comptroller	<ul style="list-style-type: none"> • Performance of TennCare audits • Performance of Managed Care Organization (MCO) audits • Performance of quarterly audits of the implementation of the <i>Grier</i> Consent Decree • Establishment of rates for Nursing Facilities and for Intermediate Care Facilities for Individuals with Intellectually Disabilities (ICFs/IID)

Agency	Functions
Department of Children's Services (DCS)	<ul style="list-style-type: none"> • Determination of Medicaid eligibility for children entering state custody or whose adoptive parents are receiving adoption assistance payments • Provision of residential treatment and targeted case management services for TennCare-eligible children in state custody • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) outreach
Department of Commerce and Insurance (TDCI)	<ul style="list-style-type: none"> • Licensure and financial oversight of Health Maintenance Organizations (HMOs)/Managed Care Organizations (MCOs), and Third Party Administrators (TPAs)/Dental Benefits Managers (DBMs)/Pharmacy Benefits Managers (PBMs) • Administration of the TennCare Claims Processing Panel and independent Review Process for review of disputed claims submitted by providers • Establishment and enforcement of uniform claim form instruction standards • Administration of annual HMO/MCO network adequacy study required by T.C.A. § 56-32-131 • Operational oversight of HMOs/MCOs, and TPAs/DBMs/PBMs, including: monitoring financial solvency; review and approval of holding company systems activities and transactions; monitoring timeliness and accuracy of claims processing and payment of provider claims; subcontract and provider agreement review and approval; review of evidence of coverage, including member handbooks and provider manuals; and state law and Contractor Risk Agreement (CRA) compliance of HMO/MCO, TPA/DBM/PBM operational subcontractors
Department of Education (DOE)	<ul style="list-style-type: none"> • EPSDT outreach
Department of Health (DOH)	<ul style="list-style-type: none"> • EPSDT outreach • EPSDT screenings • Provision of dental screenings and services to children • Presumptive eligibility determinations for pregnant women • Presumptive eligibility determinations for women needing treatment for breast and/or cervical cancer • Enrollee education and advocacy
Department of Human Services (DHS)	<ul style="list-style-type: none"> • Acceptance and transmission of paper applications and verification documents from applicants to the Bureau of TennCare • Provision of computer kiosks in each county office for applicants' to file online applications

Agency	Functions
Department of Intellectual and Developmental Disabilities (DIDD)	<ul style="list-style-type: none"> • Provision of home and community based waiver program services • Provision of Self-Determination Waiver Program services • Provision of services related to the Preadmission and Resident Review
Department of Mental Health and Substance Abuse Services (DMHSAS)	<ul style="list-style-type: none"> • Consultation on the behavioral health component of the TennCare Demonstration Waiver • Obtainment of attestations from psychiatric residential facilities on compliance with CMS standards on the use of seclusion and restraint

A number of contractors are involved in delivering TennCare services. These contractors include all of the managed care entities (MCOs, DBM, and PBM) listed in Attachment D plus other major contractors shown in Table 1-2.

Table 1-2: Major TennCare Administrative Contractors

Contractor	Major Functions
Hewlett-Packard (HP)	<ul style="list-style-type: none"> • Claims processing for long-term services and supports • Claims processing for Medicare crossover payments • Maintenance of eligibility subsystem • Maintenance of encounter data • Ad hoc and regular reports
KePRO	<ul style="list-style-type: none"> • Review of medical appeals • Assistance with medical policy
Volunteer State Health Plan (VSHP)	<ul style="list-style-type: none"> • Administration of TennCare Select contract
QSource (EQRO)	<ul style="list-style-type: none"> • Quality reviews of MCOs • Special studies
Health Management Systems (HMS)	<ul style="list-style-type: none"> • Estate recovery • Insurance recovery – medical subrogations • Insurance verifications • Review of provider accounts – to determine if overpayments have occurred

TennCare programs operate almost completely in a managed care environment and use various managed care entities to deliver covered services to enrollees. Table 1-3 below lists the types of managed care entities used and the reimbursement and rate-setting methodologies for each.

Table 1-3: Types of Managed Care Entities

Type of Entity	Balanced Budget Act (BBA) Definition	Description of Services Provided	Reimbursement and Rate-Setting Methodology
Managed Care Organizations (MCOs) – at full risk	MCO	Physical health services, behavioral health services, and long-term services and supports	MCO rates are actuarially certified by an independent third party actuary
TennCare Select – non-risk or partial risk	Prepaid Inpatient Health Plan (PIHP) ⁶	Physical health services, behavioral health services, and long-term services and supports for enrollees selected for participation in TennCare Select (rather than one of the full-risk MCOs)	Provider payment rates negotiated between the PIHP and providers; administrative fee, approved by CMS, paid to the PIHP
Dental Benefits Manager (DBM) – partial risk	Prepaid Ambulatory Health Plan (PAHP) ⁷	Dental benefits for all TennCare enrollees with this coverage	Provider payment rates are established within DBM contract as approved by CMS; administrative fee, approved by CMS, is paid to the DBM
Pharmacy Benefits Manager (PBM) – non-risk (may be renegotiated as at risk)	Prepaid Ambulatory Health Plan (PAHP)	Pharmacy benefits for all TennCare enrollees with this coverage	Provider payment rates are established in accordance with the State Plan; administrative fee, approved by CMS, is paid to the PBM

Source: STC #36

⁶ 42 C.F.R. § 438.2

⁷ Ibid.

Section 1.4 TennCare Program Integrity

1.4.1 Philosophy of TennCare Program Integrity

The Bureau has a strong commitment to program integrity. The Bureau protects its program, and the well-being of its program enrollees, by: detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; providing guidance to its Managed Care Contractors (MCCs) and other involved parties; and holding accountable those who do not meet program requirements or who violate state and/or federal laws.

The Tennessee General Assembly has declared it to be public policy of the State of Tennessee that “TennCare fraud and abuse [will] be identified and dealt with aggressively and appropriately.”⁸

1.4.2 Discussion of Program Integrity

Many Bureau offices and divisions have a role to play in ensuring the integrity of the TennCare program. The Bureau office with the most explicit responsibility for ensuring program integrity is the Office of Program Integrity (OPI). Within OPI, there are two (2) units with distinct responsibilities: Statistics and Investigations.

Through its Statistics and Investigations Units, OPI performs the following functions:

- Fraud analytics for both providers and enrollees
- Surveillance and utilization review/fraud and abuse subsystems oversight
- Provider Fraud database
- Audits/reviews
- Provider investigations
- Oversight of Managed Care Entities fraud, waste, and abuse efforts

Although the scope of the Bureau’s program integrity activities is extensive, it is important to note that other State agencies outside of the Bureau also play important roles in ensuring the integrity of the TennCare program, including the Office of the Attorney General (OAG), the Office of the Inspector General (OIG), and the Tennessee Bureau of Investigation’s Medicaid Fraud Control Unit (TBI MFCU).

⁸ Preamble to the “TennCare Fraud and Abuse Reform Act,” T.C.A. § 71-5-2502.

Chapter 2:

Eligibility and Enrollment



TennCare II Operational Protocol

Section 2.1 Overview of TennCare Eligibility

This chapter describes the populations covered by the TennCare program, as well as the eligibility and enrollment criteria for both **Medicaid eligibles** and **Demonstration eligibles**.

“Medicaid eligibles” are persons who meet the criteria for one of the Medicaid categories covered by the TennCare program, and are enrolled in TennCare Medicaid. “Demonstration eligibles” are persons who do not meet the criteria for a Medicaid category, but meet the criteria for one of the Demonstration categories. These are persons who would not be eligible for benefits in the absence of the TennCare Waiver, or Demonstration. Demonstration eligibles are enrolled in TennCare Standard.

An individual must meet the criteria for either a TennCare Medicaid or TennCare Demonstration category in order to be eligible for TennCare program benefits. Medicaid categories are established by federal law, with some categories being **mandatory** for states, and other being **optional**. The Demonstration categories, which are not established in federal law, must be formally approved by CMS as part of the TennCare 1115 waiver. States do not have the option of choosing to cover certain people—or groups of people—without explicit federal approval.

Effective January 1, 2014, as a result of the Affordable Care Act, significant changes occurred in the Medicaid eligibility criteria and determination process. These changes included combining and/or restructuring eligibility groups, as well as the implementation of the Modified Adjusted Gross Income (MAGI) standard for eligibility determinations. MAGI consists of a household’s Adjusted Gross Income (AGI), as reported on annual tax forms, increased by any excluded foreign or Social Security Income, and any tax-exempt interest earned or accrued. Most Medicaid eligibility groups are now considered “MAGI groups”; however, there are a few “non-MAGI groups” which are primarily associated with Long-Term Services and Supports (LTSS) eligibility and eligibility for a Medicare Savings Program (e.g., QMB, SLMB).

When the MAGI standards went into effect, Tennessee had the choice of conducting an applicant’s MAGI-based Medicaid eligibility determination, or allowing the Federally Facilitated Marketplace (FFM) to make these determinations. The Bureau elected to have the FFM conduct MAGI-based Medicaid eligibility determinations, until such time as the State can implement a new application and eligibility system.

2.1.1 Aliens and Refugees

Qualified aliens, including refugees, are eligible for benefits if they meet the criteria for either a TennCare Medicaid or TennCare Standard category. They are enrolled in MCOs in the same manner as all other TennCare program enrollees. Payments for emergency services furnished to illegal and ineligible aliens are provided as federally mandated.

Reference: See the following Policy Statements for a more detailed explanation:

EED 06-002 – TennCare/Medicaid for Qualified Aliens

<http://www.tn.gov/tenncare/forms/eed06002.pdf>

EED 05-001 – Emergency Medical Services for Illegal and Ineligible Aliens

<http://www.tn.gov/tenncare/forms/eed05001.pdf>

2.1.2 TennCare and Medicare Eligibility

Some Medicare beneficiaries are also eligible for Medicare cost-sharing and premium assistance from the TennCare program. Individuals who have Medicare and are also eligible for TennCare program assistance are called “dual eligibles.”

Categories of Medicare cost-sharing and premium assistance are as follows:

- **Qualified Medicare Beneficiaries (QMBs).** These are Medicare beneficiaries whose income is less than or equal to 100% of poverty. If they are also eligible in a TennCare category, they are called **QMB-Pluses**.
- **Specified Low Income Medicare Beneficiaries (SLMBs).** These are Medicare beneficiaries whose income is between 100% and 120% of poverty. If they are also eligible in a TennCare category, they are called **SLMB-Pluses**.
- **Qualifying Individuals (QIs).** These are Medicare beneficiaries with incomes between 120% and 135% of poverty. They are not eligible for the TennCare program.
- **Qualified Disabled Working Individuals (QDWIs).** These are Medicare beneficiaries with disabilities who also have jobs, whose incomes are less than 200% of poverty. They are not eligible for the TennCare program.
- **Other Medicare/TennCare duals.** These are higher income Medicare beneficiaries who do not belong in any of the above categories but who also qualify in a TennCare category.

Medicare beneficiaries who are not also eligible in a TennCare category, but who are eligible for the TennCare program to pay some, or all, of their Medicare cost-sharing, are called “Partial Benefit Duals.” QMB-only’s, SLMB-only’s, QIs, and QDWIs are all Partial Benefit Duals.

Medicare beneficiaries who are also eligible in a TennCare category are called “Full Benefit Dual Eligibles (FBDEs).” QMB Pluses, SLMB Pluses, and Other Medicare/TennCare Duals are all FBDEs.

Information about TennCare benefits for each Medicare eligibility group is contained in Chapter 3, “Benefits and Cost Sharing.”

Reference: See TennCare Rule 1200-13-17

2.1.3 Procedures for Accommodating Persons with Other Disabilities and Limited English Proficiency

Since 2001, the Bureau’s Division of Member Services and the Office of Non-discrimination Compliance have met on a regular basis with various consumer advocacy groups and other interested individuals to continue a dialogue about TennCare and enrollee issues, especially those issues involving communication with enrollees with disabilities or limited English proficiency. These are issues that are important to both the Bureau and enrollee advocates.

In addition, the Office of Non-discrimination Compliance has established two Title VI advisory committees. The Internal Committee consists of TennCare employees from various divisions. The External Committee consists of Bureau of TennCare employees, employees of other State departments, representatives of various consumer advocacy groups, and other interested individuals who have been invited to help (such as representatives of Vanderbilt University and Belmont University). Representatives of the TennCare Managed Care Contractors (MCC) also participate in the External Committee meetings.

These groups meet regularly to discuss advocacy/outreach issues and other topics, such as assisting providers in understanding cultural differences among their patients and how they affect medical care. Such meetings are beneficial in that they provide a better understanding of the issues involved and improve communication with the TennCare enrollee population.

2.1.3.1 Individuals with limited English proficiency (LEP)

The Bureau has made a number of provisions to assist individuals with LEP as they navigate the eligibility processes and benefits of the TennCare program.

The Bureau offers applications in English and Spanish, and all enrollee notices are mailed in both languages. An insert in each mailing provides a toll-free phone number that individuals may call for assistance with translation. These inserts communicate this information in Arabic, Somali, Kurdish-Badinani, Kurdish-Sorani, Bosnian, and Vietnamese. All notices contain the telephone number of TNHC. Individuals who call TNHC can be connected with interpretation services, if necessary.

The Bureau maintains a contract with the Tennessee Community Services Agency (TNCSA), an organization that provides outreach assistance and advocacy for persons with limited English proficiency, as well as interpretation services to TennCare enrollees and applicants. Additionally,

the Bureau uses the Tennessee Relay Service (TNRS), which provides assisted telephone service to those with speech, hearing, and visual impairments.

2.1.3.2 Individuals with physical and other disabilities

The following strategies are in place to assist clients with a wide range of disabling conditions that might interfere with their ability to understand the eligibility process.

The Bureau makes a number of accommodations available to the TennCare population, including:

- Letting the enrollee/applicant designate a third party to represent him during the eligibility determination process;
- Conducting interviews with an individual over the phone;
- Conducting interviews at an alternative site that is easier for the enrollee/applicant to access;
- Conducting interviews outside of normal working hours; and
- In extreme cases, conducting interviews in the enrollee's home.

2.1.4 HIPAA Statement of Coverage

Enrollees losing eligibility for the TennCare program are provided a Certificate of Creditable Coverage, as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended.

Individuals who voluntarily terminate their TennCare coverage will also be provided a timely Certificate of Creditable Coverage. Should a former enrollee need an additional HIPAA Certificate(s), he may request one by calling the Tennessee Health Connection (TNHC) at 1-855-259-0701.

Section 2.2 TennCare Medicaid

2.2.1 TennCare Medicaid Eligibility

2.2.1.1 TennCare Medicaid eligibility categories

The TennCare Medicaid eligibility groups are summarized in Table 2-1. Detailed descriptions of each category can be found in Special Term and Condition (STC) #17 of the TennCare waiver.

Note: Some individuals enrolled in the CHOICES program are Medicaid eligibles. In an effort to reduce confusion, the CHOICES eligibility groups are shown in Section 2.4.

Table 2-1: Major TennCare Medicaid Eligibility Categories

TennCare Medicaid Categories	Brief Description
<i>Mandatory Categories</i>	
Infants and children under age 19	Under TennCare, the maximum income standard is up to 195% of poverty for infants under age 1; up to 142% of poverty for children from ages 1 to age 6; and up to 133% of poverty for children from ages 6 to age 19.
Pregnant and postpartum women	Under TennCare, the maximum income standard is up to 195% of poverty.
Infants born to Medicaid-eligible pregnant women	Children born to Medicaid-eligible pregnant women are eligible for Medicaid throughout the first year of life.
Parents and other caretaker relatives	Parents and other caretaker relatives, and his or her spouse if living with the parent or other caretaker relative, whose household income is at or below the standard established by the State plan based on the family size.
Children with IV-E foster care or adoption assistance	Children receiving foster care or whose adoptive parents receive adoption assistance payments under Title IV-E.
SSI recipients, including persons in SSI-related groups	Persons with low income who are aged, blind, or disabled.
Former foster care children	Individuals under the age of 26 who were on Medicaid in foster care when they turned age 18 or aged out of foster care in Tennessee.
<i>Optional Categories</i>	
Institutionalized individuals	Persons receiving care in Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, or HCBS waiver programs who have incomes at or below 300% of the SSI Federal Benefit Rate.

TennCare Medicaid Categories	Brief Description
Women under age 65 who need treatment for breast or cervical cancer and who are not otherwise eligible for Medicaid	These women must be screened at a site authorized by the Centers for Disease Control and Prevention and be determined to need treatment for breast and/or cervical cancer. They must not have insurance that covers this treatment, and they must not have incomes that exceed 250% of poverty.
Presumptively eligible pregnant & postpartum women	Pregnant or postpartum women with incomes up to 195% of poverty.
Medically needy pregnant women and children under age 21	Pregnant women and/or children who have sufficient unreimbursed medical bills to meet the State's Medically Needy Income Standard (MNIS).
Children with non IV-E adoption assistance	Children with special needs for whom there is a non IV-E adoption assistance agreement in effect with the State, who were eligible for Medicaid, or who had income at or below a standard established by the State

Source: STC #17

2.2.1.2 Technical eligibility criteria

Individuals applying for TennCare Medicaid must meet all of the technical requirements applicable to the appropriate category of medical assistance, as described in 42 CFR §435.

2.2.1.3 Access to insurance

TennCare Medicaid enrollees are generally not prohibited from having other health insurance, with the exception of women in the Breast and/or Cervical Cancer group. Women receiving TennCare Medicaid benefits under this category cannot have health insurance that covers treatment for their breast and/or cervical cancer. TennCare Medicaid enrollees who have other insurance, either through an employer or through purchase in the private individual market, are required to assign the benefits of such policies to the State.

2.2.1.4 Financial eligibility

Financial eligibility for Medicaid programs is generally determined based on “income” and “resources.”

- **Income** means wages, pension payments, and similar sources of regular support. A TennCare Medicaid applicant’s income level is calculated by the FFM according to the current federal poverty level (FPL) standards, using definitions of “family size” and “household income” in accordance with 42 CFR §435.603 regarding MAGI-based income methodologies. SSI applicants’ incomes are calculated according to the requirements of the SSI program.
- **Resources** are assets such as cash, bank accounts, stocks, bonds, and property. Individuals eligible for TennCare Medicaid under a category based on MAGI standards are not subjected to a resource test.

Many of the TennCare program categories refer to incomes that are established at certain percentages of the FPL--which is updated annually--according to family size. A copy of the FPL for the current year can be found at <http://aspe.hhs.gov/poverty/14poverty.cfm>

2.2.1.5 Presumptive eligibility and immediate eligibility

Pregnant women. Presumptive eligibility for pregnant women is determined consistent with the standards and criteria followed by TennCare Medicaid, and in accordance with the approved Medicaid State Plan. The Department of Health (DOH) is responsible for determining presumptive eligibility for pregnant women. During the period of presumptive eligibility, the woman is considered a “temporary” TennCare Medicaid enrollee; however, she will receive the full benefits package. Presumptively eligible pregnant women have 45 days to complete the full eligibility determination process. If the woman does not apply for ongoing TennCare Medicaid coverage during that period, she will not continue to receive benefits when her period of presumptive eligibility ends. There is only one period of presumptive eligibility allowed per pregnancy.

Women with breast and/or cervical cancer. Women who meet the criteria for this category, outlined in Table 2-1, may be determined presumptively eligible for TennCare Medicaid at the CDC site. Women with breast and/or cervical cancer who have been determined presumptively eligible have 45 days to complete the full eligibility determination process. During the period of presumptive eligibility, the woman is considered a “temporary” TennCare Medicaid enrollee; however, she will receive the full benefits package. If the woman does not apply for ongoing TennCare Medicaid coverage, she will not continue to receive benefits when her period of presumptive eligibility ends. Coverage in this category is limited to the period during which a woman requires active treatment for breast and/or cervical cancer.

Children. There is no presumptive eligibility for children; however, children entering State custody are deemed “immediately eligible” for TennCare Medicaid while their applications are being processed and will begin receiving full benefits through TennCare Select. Should the result of the eligibility determination process be that the children are not eligible for TennCare Medicaid, DCS will reimburse TennCare Select for any dollars spent on these children's behalf.

Reference: TennCare Medicaid Rule 1200-13-13-.02 & TennCare Standard Rule 1200-13-14-.02

2.2.1.6 Deemed Newborns

TennCare Medicaid coverage is automatically granted for one year to any infant born to a TennCare Medicaid-eligible mother, effective on the date of birth. (A newborn with a TennCare Standard-enrolled mother will not be granted automatic eligibility for TennCare Standard, and must be determined eligible for TennCare Medicaid in his own right to qualify for benefits.) A “deemed” newborn is not required to meet the eligibility requirement of enumeration (i.e., having, or applying for, a Social Security Number) during the first year of eligibility. However, the newborn must be enumerated by age one for continued enrollment, or prior to a determination of eligibility in any other TennCare Medicaid category, whichever occurs first.

When a pregnant woman who is an illegal or ineligible alien qualifies for TennCare payment of the delivery of her newborn, the newborn is deemed eligible for one year of the TennCare Medicaid coverage, as children born in the United States are U.S. citizens.

Reference: Policy Statement: CON 08-002 Assignment of Newborns, Coverage and Billing
<http://www.tn.gov/tenncare/forms/con08-002.pdf>

2.2.2 Applying for TennCare Medicaid

Persons meeting TennCare Medicaid eligibility criteria can apply at any time through the FFM (as stated in Section 1, the Bureau has elected for the FFM to conduct MAGI eligibility determinations pending implementation of a state-operated Medicaid eligibility system.) Applications for individuals determined eligible based in a MAGI category (or individuals who are determined ineligible based on MAGI standards, but potentially eligible under a non-MAGI category) will be transferred to the Bureau for enrollment. Individuals applying for SSI through the Social Security Administration (SSA) are automatically enrolled in TennCare Medicaid upon approval of SSI benefits.

Pregnant women and women with breast and/or cervical cancer who have been determined presumptively eligible for TennCare Medicaid must complete their application for ongoing coverage through the FFM. Women with breast and/or cervical cancer completing an application for ongoing TennCare Medicaid coverage through the FFM will be reviewed for eligibility in a MAGI-based category. If the FFM determines that the woman is not MAGI-eligible, but may be eligible under a non-MAGI category (e.g. the Breast and Cervical Cancer Category), the FFM will electronically transmit the record to the Bureau. The Bureau call center may need to contact the woman to obtain additional information required for eligibility determination. Once the requested information is received, the application will be processed to determine eligibility.

Newborns may apply for TennCare Medicaid like any other potential enrollees. The technical eligibility requirement that the newborn be enumerated may be bypassed if there is verification that an application for a Social Security number/card (Form SS-5) has been filed. A hospital worker may provide Form SS-5 to the parents, or a family representative, and assist the family in completing the form.

For access to the Federally-Facilitated Marketplace (FFM): <https://www.healthcare.gov>

The Automated Client Certification Eligibility Network for Tennessee (ACCENT) determines TennCare Medicaid eligibility for non-MAGI categories based on the information entered. An applicant's eligibility is determined within the time periods provided for in federal regulations, and the applicant is notified by the Bureau of the results of this process. Appeals of denials of TennCare Medicaid eligibility are handled by the Bureau.

Reference: See TennCare Rule 1200-13-13-.02

2.2.2.1 Effective date of eligibility

The date an individual’s TennCare Medicaid coverage begins varies on the eligibility category in which he is enrolled. See Table 2-2 below for details.

Table 2-2: Effective Date of Eligibility for TennCare Medicaid

Program	Eligibility Category	Effective Date of Eligibility
TennCare Medicaid	SSI eligibles	The date the Social Security Administration approves the individual for SSI benefits.
TennCare Medicaid	Presumptively eligible pregnant women or presumptively eligible women who have been found to need treatment for breast or cervical cancer	The date an application is approved at the Department of Health or, in the case of women needing treatment for breast or cervical cancer, at any alternative site designated by the Centers for Disease Control and Prevention.
TennCare Medicaid	All other Medicaid eligibles	The date the application is received by the state or federal agency, or the date of the qualifying event (such as the date that a spend down obligation is met), whichever is later.

2.2.2.2 Eligibility period and redetermination

Eligibility in all TennCare Medicaid categories includes a “begin date” and an “end date.” A person may continue receiving TennCare program benefits past his end date only if he has received notice of—and had the opportunity to complete—the redetermination process, and been determined to meet the criteria for continued eligibility through the process. All enrollees must re-establish their ongoing eligibility for TennCare Medicaid on at least an annual basis. *Ex parte* reviews⁹ conducted by the Bureau, responses to Request for Information (RFI) notices, and/or interviews between the Bureau eligibility worker and the enrollee are the means by which this is accomplished. Enrollees will be required to provide updated information on their employment, income, assets, family status and other pertinent issues.

There are certain categories that have automatic eligibility periods. Although the length of these eligibility periods are established, enrollees receive notice of, and are screened for, other TennCare program categories for which they may be eligible prior to disenrollment from TennCare Medicaid. The categories with automatic eligibility periods are as follows:

- **Pregnant women and newborns.** Pregnant women are eligible for TennCare Medicaid coverage for the length of their pregnancy, plus 60 days postpartum. The newborn is

⁹ An “ex parte review” is one done without the presence of the enrollee. TennCare uses the data they have access to and tries to determine the enrollee’s eligibility to continue in TennCare based on that data without any input from the enrollee.

automatically given one year's eligibility in TennCare Medicaid if the mother was enrolled in TennCare Medicaid on the day of birth.

- **Women receiving treatment for breast and/or cervical cancer.** A woman in this category remains eligible until one of the following events: she no longer requires active treatment for her cancer, as determined by her physician (and she continues to meet the other requirements of the program); she gains health insurance that provides coverage for treatment of breast and/or cervical cancer; or, she turns 65 years old. TennCare's Office of the Chief Medical Officer is responsible for reviewing the information submitted by the woman's physician for determination of ongoing eligibility.
- **SSI beneficiaries.** Individuals who are enrolled in TennCare Medicaid because they receive SSI benefits from the Social Security Administration remain eligible for as long as they are SSI-eligible.
- **Medically Needy enrollees.** An enrollee in TennCare Medicaid under the Medically Needy category is automatically eligible for one year, unless there is a change in the circumstances under which they met the eligibility criteria.

TennCare Medicaid enrollees must report to the Bureau changes in income, family status or living circumstances (including address changes) that occur during the eligibility period within 10 days. Failure to report such changes in a timely manner may result in termination from the program.

Reference: See Rules 1200-13-13-.02

Section 2.3 TennCare Standard

2.3.1 TennCare Standard Eligibility

Persons who meet the technical and financial eligibility requirements of the Title XIX and Title XXI Demonstration categories in the TennCare waiver are enrolled in TennCare Standard. (TennCare Demonstration categories related to the CHOICES program are discussed in Section 2.4.)

2.3.1.1 TennCare Standard eligibility categories

The TennCare Standard eligibility groups are summarized in Table 2-3. Detailed descriptions of each category can be found in Special Term and Condition (STC) #17 of the TennCare waiver.

Table 2-3: Major TennCare Standard Eligibility Categories

TennCare Categories	Brief Description
Title XIX Medically Eligible children	<p>Children under age 19 with incomes above 211% of poverty, who have been determined to be Medically Eligible.</p> <p>Membership in this category is limited to children already enrolled in it, and to children who are losing eligibility for TennCare Medicaid or TennCare Standard under another category.</p>
Title XXI ¹⁰ Medicaid Expansion ¹¹ children	<p>Children under age 19 with incomes 211% of poverty and below who lack access to insurance.¹²</p> <p>Membership in this category is limited to children already enrolled in it and to children who are losing eligibility for TennCare Medicaid.</p>

¹⁰ Title XXI is the Children’s Health Insurance Program. Tennessee’s CHIP is a “combination” program, with separate CHIP and Medicaid components. Children in this Medicaid Expansion category receive TennCare coverage, but their services are paid for with Title XXI funds, instead of Title XIX funds.

¹¹ Upon implementation of the ACA, the term “Medicaid Expansion” was used to refer to two groups of individuals potentially eligible for Medicaid coverage due to new eligibility rules. The first group, consisting of children under age 19 with incomes between 100% and 138% of poverty, was required for all states. The second group, consisting of adults age 19-64 with incomes up to 138% FPL, became optional for states following a March 2012 U.S. Supreme Court ruling. **Note:** For the purposes of this document, the “Medicaid Expansion” category refers solely to the Title XXI TennCare Standard group in Table 2-3.

¹² As of January 1, 2014, implementation of the Marketplace virtually eliminates “lack of access to insurance.” However, subsidized insurance plans offered through the Marketplace are classified as an “insurance affordability program”—the same as Medicaid and CHIP programs. Eligibility determinations for these programs are made in the following order: 1) Medicaid; 2) CHIP; and 3) Marketplace. Therefore,

TennCare Categories	Brief Description
Standard Spend Down (SSD)	Adults age 21 and older who are not pregnant or post-partum; who are aged, blind, or disabled, or caretaker relatives of Medicaid-eligible children; and who have sufficient unreimbursed medical bills to meet the same Medically Needy Income Standard (MNIS) that is used in the Medicaid Medically Needy program. Enrollment in this group is open only during specified open enrollment periods.

2.3.1.2 Technical eligibility criteria

All members of the TennCare Demonstration population must meet the following technical eligibility criteria: be residents of the State of Tennessee; be United State citizens or legal resident aliens; have met Social Security enumeration requirements; and not be incarcerated.

Reference: See Rule 1200-13-14-.02

2.3.1.3 Lack of access to insurance

In order to qualify for TennCare Standard in either the Medically Eligible or the Medicaid Expansion categories, the child must lack access to health insurance. If the child, or the child’s caregiver relative, is employed, a statement must be provided from the employer concerning the lack of availability of group health insurance. The types of policies that count as “insurance” and the types of policies that do not count as “insurance” for purposes of determining an individual’s access to insurance are presented in Attachment B.

Reference: See Rule 1200-13-14-.02

2.3.1.4 Financial eligibility

Sources of income for children in TennCare Standard are the same as those for children in TennCare Medicaid (See Section 2.2.1.4). Resources are not counted for children in TennCare Standard, except in the instance of a child who might qualify for the CHOICES 1 and 2 Carryover Group.

Individuals determined eligible for Standard Spend Down during the open enrollment period have the same spend down levels and resource requirements as pregnant women and children served in the TennCare Medicaid Medically Needy program. They must “spend down” to the State’s Medically Needy Income Standard (\$241 for a family of 1; \$258 for a family of 2; \$317 for a family of 3; etc.), and their resources cannot exceed \$2,000 for a family of 1 or \$3,000 for a family of 2.

“lack of access to insurance” for an individual being reviewed for eligibility in a TennCare program category that requires such refers to insurance available from a source other than the Marketplace.

2.3.1.5 Rollover eligibility

If an enrollee under the age of 19 loses eligibility for TennCare Medicaid for reasons other than incarceration or non-resident status, he may be eligible for enrollment in TennCare Standard. People who enroll in TennCare Standard following loss of TennCare Medicaid eligibility are called “Medicaid Rollovers.”

Enrollees under the age of 19 who roll over to TennCare Standard will receive the same benefits that were available to them in their TennCare Medicaid benefit package, unless they will be receiving LTSS through TennCare CHOICES. They will also be subject to copayment requirements as described in Section 3.2, TennCare Cost Sharing.

Reference: See TennCare Rule 1200-13-14-.02 and STCs # 19 Child Non-State Plan Demonstration Population Categories for Which Enrollment is Closed) & # 20 (Rollover Definitions)

2.3.2 Applying for TennCare Standard

This section provides information about applying for TennCare Standard.

2.3.2.1 Medicaid Expansion category

Children under age 19 whose TennCare Medicaid is ending are screened for eligibility in the TennCare Standard Medicaid Expansion category. In order to qualify for TennCare Standard under this category, the child must lack access to other insurance and have an income of 211 percent, or below, FPL. Children who qualify in this category “roll over” into TennCare Standard from TennCare Medicaid without experiencing a break in coverage.

Reference: See TennCare Rule 1200-13-14-.02

2.3.2.2 Medically Eligible category

Children under age 19 whose TennCare Medicaid eligibility is ending, but who do not qualify for TennCare Standard in the Medicaid Expansion category due solely to a household income above 211 percent FPL, may be eligible in the Medical Eligibility category if they have medical conditions such that, prior to the implementation of the ACA, they would have been considered “Uninsurable.” There are two options that a child may use to apply for TennCare Standard coverage in the Medical Eligibility category:

- Based on claims information, the Bureau may determine that a child has a medical or behavioral condition that indicates he is medically eligible for TennCare Standard.
- A child must either have his physician attest that he has a medical condition on *TennCare’s List of Qualifying Medical Conditions Used to Determine Medical Eligibility*

(see Attachment C),¹³ or the child must submit, along with the completed application, appropriate medical records¹⁴ to support the attestation of a medical condition **not** included on the TennCare list, and a release for additional medical records, if necessary. Each of the methods above requires all supporting documentation to be submitted with the completed application. Applications that are not complete, or are not accompanied by the required documentation, will not be processed.

Reference: See Rule 1200-13-14-.02.

2.3.2.3 Standard Spend Down (SSD) category

The SSD category is designed for a certain number of non-pregnant/postpartum adults, age 21 or older, who are caretaker relatives of Medicaid-eligible children, or are aged, blind, or disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the Medicaid State Plan. Individuals can enroll in the SSD category only during open enrollment periods announced by the State.

Reference: See Section 2.1.1 and STC # 21(a) (Adult Non-State Plan Demonstration Population Categories).

2.3.2.4 Effective date of eligibility

The date an individual’s TennCare Standard coverage begins varies on the eligibility category in which he is enrolled. See Table 2-4 below for details.

Table 2-4: Effective Date of Eligibility for TennCare Standard

Program	Eligibility Category	Effective Date of Eligibility
TennCare Standard	Medicaid Expansion children under 19	The day following the TennCare Medicaid coverage end date.
TennCare Standard	Medically Eligible children under 19	The day following the TennCare Medicaid coverage end date.

¹³ The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring and/or treatment.

¹⁴ “Medical records” are defined in T.C.A. § 63-2-101(c)(4) as “medical histories, records, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, x-ray and radiology interpretations, physical therapy charts and notes, and lab reports.” Applicants for Medically Eligible status are not required to submit all the medical records they may have. Rather, they are required to submit a copy of a current medical record or portion of a medical record that documents the existence of the medical condition they claim to have.

Program	Eligibility Category	Effective Date of Eligibility
TennCare Standard	SSD eligibles (Call-in Group) – see Part III of Section XIII in the STCs	The date the call was received by the State during an announced open enrollment period, assuming the person is ultimately determined eligible, or the date the spend down is met, whichever is later. The latest date by which spend down can be met is the end of the one-month budget period – in this case, the end of the month of the original call to the Call-In Line.

Reference: See TennCare Standard Rule 1200-13-14-.02

2.3.2.5 Eligibility period and redetermination

Similar to TennCare Medicaid, eligibility in all TennCare Standard categories includes a “begin date” and an “end date.” A person who wishes to continue receiving TennCare program benefits must be determined eligible through the redetermination process. All enrollees must re-establish their ongoing eligibility for TennCare Standard on at least an annual basis. TennCare Standard enrollees will be required to provide updated information on their employment, income, assets, family status and other pertinent issues during the redetermination process.

Children enrolled in the Medically Eligible category will have to renew their TennCare Standard coverage each year and provide updated information on residency, changes in income, and enrollment in third party insurance. Medically Eligible enrollees will not be required to have their medical criteria re-verified every year, as most qualifying conditions are chronic, life-long conditions; however, they may be required to submit proof of continued medical eligibility periodically during redetermination.

An enrollee in the TennCare Standard Spend Down category is automatically eligible for one year, unless there is a change in the circumstances under which they met the eligibility criteria.

Section 2.4 TennCare CHOICES

2.4.1 TennCare CHOICES Eligibility

CHOICES is the program in which Nursing Facility (NF) services for eligible individuals of any age, and Home and Community Based Services (HCBS) for individuals aged 65 and older and/or adults aged 21 and older with physical disabilities, are integrated into TennCare’s Managed Care system. The CHOICES program allows eligible Tennesseans in need of long-term services and supports (LTSS) to receive care in their homes and communities, when appropriate.

2.4.1.1 TennCare CHOICES eligibility categories

There are three principal eligibility groups in TennCare CHOICES.

- CHOICES 1 is for individuals receiving services in an NF. These individuals are enrolled in TennCare Medicaid. Individuals of any age can be enrolled in CHOICES 1.
- CHOICES 2 is for individuals who meet the NF Level of Care (LOC) criteria and are receiving HCBS as an alternative to NF care. Individuals in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or TennCare Standard, if they are not SSI-eligible. The CHOICES 2 group that is enrolled in TennCare Standard is called the “CHOICES 217-Like Group.” Individuals in CHOICES 2 must be age 65 or older, or age 21 or older and physically disabled. CHOICES 2 has established enrollment targets for each Demonstration year and any changes require CMS approval prior to implementation.¹⁵
- CHOICES 3 is for individuals age 65 and older, or age 21 and older with disabilities, who do not meet the NF LOC criteria but are at risk of NF placement, and who are receiving HCBS to delay or prevent NF placement. Individuals who are enrolled in TennCare Medicaid as SSI-eligibles would be eligible to participate in CHOICES 3, but this category has never been open. However, an “Interim CHOICES 3” eligibility group (discussed further below) is currently open for enrollment.

On July 1, 2012, the Bureau changed the level of care criteria for Nursing Facilities (NF LOC). As part of this change, the Bureau, with CMS approval, opened some new groups in order to ensure continued eligibility for persons already receiving LTSS who met the old NF LOC but not the new NF LOC, and also to ensure that persons who could have enrolled in CHOICES prior to July 1, 2012, still had an opportunity to enroll, as required by the Maintenance of Effort (MOE) requirements of the Affordable Care Act. The new groups include the following:

¹⁵ According to STC 32.d.i, enrollment target for the current Demonstration approval period are as follows: DY 12 (2013-14)- 12,000 to 16,000; DY 13 (2014-15)- 13,500 to 17,500; and DY 14 (2015-16)- 15,000 to 18,500.

- Interim CHOICES 3 is for persons who: meet the NF LOC criteria in place as of June 30, 2012, but not the NF LOC criteria in place as of July 1, 2012; meet all other CHOICES requirements; and are receiving CHOICES HCBS. Persons enrolled in Interim CHOICES 3 are SSI eligibles and people who qualify for a TennCare Standard category called the CHOICES At Risk Demonstration Group. There is no enrollment target for Interim CHOICES 3. The category was originally set to close to new enrollment on December 31, 2013; however, it has been extended through June 30, 2015. Persons who are enrolled in the category at that time may remain in the category as long as they meet program criteria and maintain continuous enrollment.
- The CHOICES 1 and CHOICES 2 Carryover Group is for persons enrolled in CHOICES on June 30, 2012, who, upon re-verification of their eligibility, are found to meet the old NF LOC criteria but not the new NF LOC criteria, as well as all other program criteria. These persons may continue to be eligible in the CHOICES group in which they were enrolled on June 30, 2012.

The Bureau has one PACE program that is located in Chattanooga. PACE also uses the NF LOC criteria. The Bureau has opened a PACE Carryover Group for persons who were enrolled in PACE on July 1, 2012, and who upon re-verification of their eligibility, are found to meet the old NF LOC criteria but not the new NF LOC criteria, as well as all other program criteria.

Reference: STC # 18 (TennCare CHOICES Eligibility Groups) and STC #21 (Adult Non-State Plan Demonstration Population Categories).

2.4.1.2 Technical eligibility requirements

Individuals applying for TennCare CHOICES must meet all of the technical requirements applicable to one of the available LTSS categories, as detailed in TennCare Rule 1200-13-01-.05. The category for which the individual is eligible is dependent upon his LOC determination, his TennCare eligibility group, and the ability of the state to provide him with safe, appropriate, and cost-effective LTSS.

2.4.1.3 Access to insurance

Individuals who have long term care (LTC) insurance must report these policies to the Bureau upon enrollment in TennCare CHOICES. Benefits from an LTC policy must be assigned to the NF or residential facility, or to the MCO if the enrollee is receiving HCBS. If the policy does not allow the benefits to be assigned, the individual must make payments to the NF, residential facility, or MCO, upon receipt of benefits.

Reference: TennCare Long-Term Care Programs Rules 1200-13-01-.08

2.4.1.3 Financial eligibility

Financial eligibility for participation in TennCare CHOICES varies based on the eligibility group.

- For CHOICES 1, financial eligibility is established according to the institutional income and resource rules in the Medicaid state plan.

- For CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or, if the individual is a member of the CHOICES 217-like HCBS Group, he must meet institutional income and resource rules applicable if HCBS were being provided under a 1915(c) waiver for persons who are elderly and/or physically disabled.
- For CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.
- For Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or, if the individual is a member of the At Risk Demonstration Group, he must meet institutional income and resource rules.

Reference: STC # 32(b) (Eligibility for TennCare CHOICES Benefits)

2.4.2 Applying for TennCare CHOICES

Application procedures for TennCare CHOICES differ depending upon whether the person is already enrolled in the TennCare program.

Individuals not already enrolled in the TennCare program who wish to enroll in CHOICES must do so through the State's Single Point of Entry (SPOE). The Bureau has contracted with the Area Agencies on Aging and Disability (AAADs) to serve as the SPOEs across the State. A list of the AAADs and their contact information can be found on the website of the Tennessee Commission on Aging and Disability: <http://www.tn.gov/comaging/localarea.html>.

Once the SPOE has gathered the necessary information and reviewed it for Medicaid eligibility, the Bureau will determine whether the individual meets the criteria of the Institutional category of eligibility or some other Medicaid category. The Bureau will also determine the amount of patient liability and assess whether any transfer of assets occurred in violation of the Deficit Reduction Act (DRA).

Individuals who are enrolled in the TennCare program, but who are not already participating in CHOICES, may request enrollment through their MCOs. They may also be identified through other mechanisms that would trigger an assessment of their need for long-term services and supports by the MCO. A person who is already enrolled in the TennCare program shall not be required to file a new application to qualify in a CHOICES category. The Bureau will only require additional information needed to determine whether the individual meets LOC criteria and financial eligibility requirements. Such information shall be submitted by the MCO as an attachment to the CHOICES Enrollment Form.

2.4.2.1 Enrollment targets for TennCare CHOICES

The purpose of having an enrollment target is to permit the CHOICES program to grow in a controlled manner, while assuring that the individuals enrolled in the program are served appropriately and cost-effectively, within available state and federal resources. CHOICES 2 is currently the only open group with an enrollment target, as was discussed in Section 2.4.1.1.

Once the enrollment target for CHOICES 2 is reached, additional individuals may not enroll in the category, except as described in the following section. A CHOICES waiting list may be established

when there are an insufficient number of slots to accommodate those wishing to receive HCBS through CHOICES 2. The waiting list will be managed on a statewide basis using a standardized assessment tool and in accordance with objective criteria established by the Bureau, and applied consistently across the State. The waiting list will be managed on a statewide basis using a standardized assessment tool and in accordance with objective criteria established by the Bureau, and applied consistently across the State.

2.4.2.2 HCBS as a cost-effective alternative

If a TennCare Medicaid enrollee meets the criteria for CHOICES 2, but cannot be enrolled because the enrollment target has been met, the individual may be offered HCBS as a cost-effective alternative under a Plan of Care, at the sole discretion of the MCO. The use of HCBS as a cost-effective alternative would be appropriate if the individual would be receiving services in a NF, absent the provision of HCBS. The individual would be served in CHOICES 2 outside the enrollment target, but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

2.4.2.3 Transition from CHOICES 1 to CHOICES 2

An enrollee being served in CHOICES 1 who meets the requirements for CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if the CHOICES 2 enrollment target has been reached. This individual would be served in CHOICES 2 outside the enrollment target, but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

2.4.2.4 Reserve capacity

TennCare may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are at imminent risk of being placed in a NF, absent the provision of HCBS.

2.4.2.5 Effective date of eligibility

CHOICES 1. In order for an individual to be eligible for CHOICES 1 benefits, he must have completed the Pre-admission Screening and Resident Review (PASRR), have an approved, unexpired Pre-admission Evaluation (PAE) for NF LOC, be approved for TennCare reimbursement of NF services, and be admitted to a NF. The effective date of eligibility may be retroactive to the date of admission, or the date of the application, whichever is later.

CHOICES 2. In order for an individual to be eligible for CHOICES 2 benefits, he must have an approved, unexpired PAE for NF LOC, and must be approved for TennCare reimbursement of LTSS. The effective date of eligibility is the date the application for CHOICES 2 is approved by the Bureau.

CHOICES 3. In order for an individual to be eligible for CHOICES 3 benefits (including Interim CHOICES 3), he must meet the criteria for At Risk of Institutionalization and must be approved for TennCare reimbursement of LTSS. The effective date of eligibility is date the application for CHOICES 3 is approved by the Bureau.

2.4.2.6 Eligibility period and redetermination

The eligibility period for an individual enrolled in TennCare CHOICES is based on the continued medical need, as indicated by the LOC assessment. The MCO is responsible for assessing the individual's LOC for continued eligibility at least once in a 12 month period. An MCO may conduct an LOC assessment more frequently, as necessary based on the individual's PAE expiration date (if applicable) or a change in the status of his condition. To maintain continued eligibility, individuals must meet the LOC requirements under which they were originally determined eligible for TennCare CHOICES. Individuals who are determined ineligible for continued enrollment based on the MCOs LOC assessment must submit documented proof of continued eligibility in the current category, or apply for enrollment in another TennCare program category, in order to maintain TennCare benefits

In addition to reassessment of medical eligibility, individuals must continue to meet financial requirements for TennCare CHOICES in order to maintain continued enrollment. The Bureau is responsible for redetermination of financial eligibility at least once in a 12 month period. Individuals who are determined ineligible based on the financial criteria for the TennCare CHOICES category will be given the opportunity to qualify for another TennCare program category prior to disenrollment.

Section 2.5 Enrollment Process

2.5.1 Procedures for Enrollment into MCOs

At the time an application for TennCare is completed, the applicant selects a Managed Care Organization (MCO) from among those available. All family members on the same TennCare case must enroll in the same MCO, except for individuals eligible to enroll in TennCare Select. Applicants who fail to select an MCO at the time of application are automatically assigned to one by the Bureau. Enrollment in the MCO will be effective on the same day TennCare program coverage becomes effective. The Bureau will send a letter to each enrollee, notifying him of his assigned MCO. Once enrolled, individuals have 45 calendar days (inclusive of mail time) from the date of the letter to change MCOs, if they are dissatisfied with their assignment for any reason. After the 45-day change period has ended, enrollees can only change MCOs based on proof of hardship criteria (see Attachment E). The procedure for making an MCO change after the initial 45-day period is described in Section 2.3.4 below.

Individuals who are returning to the TennCare program after a lapse in eligibility will initially be reassigned to their former MCO, if the lapse lasted for less than 63 days. Returning members will be sent an MCO assignment notification letter, as described above, and are given 45 calendar days (inclusive of mail time) from the date of the letter to change MCOs if they wish. After the initial 45-day period, enrollees electing to change MCOs must follow the procedure described in Section 2.3.4 below.

Deemed newborns—as described in Section 2.2.1.6—are automatically assigned to the same MCO as the mother, unless the mother is enrolled in TennCare Select. In that event, the newborn will go through the random assignment process.

The Bureau also permits changes to place all family members in the same MCO, unless one of the family members is in TennCare Select. The MCC Change Unit within the Division of Member Services reviews and issues decisions on MCO change requests related to medical or service access issues.

Immediately upon being notified of an enrollee's assignment to its plan, an MCO issues an individual enrollee identification card, which the enrollee uses to access services from MCO network providers. Each MCO is responsible for providing a Bureau-approved Member Handbook and a Provider Directory that lists the providers participating in the MCO's network.

Attachment D lists MCOs that have current TennCare program contracts to provide covered services to enrollees, including currently participating Dental and Pharmacy contractors.

2.5.2 Procedures for Enrollment into TennCare Select

TennCare Select is a special MCO that operates statewide to serve certain enrollees identified by the Bureau. Enrollees cannot choose TennCare Select as their MCO, but must be assigned by the State based on specific eligibility criteria, including:

- Children who are eligible for SSI.
- Children in State custody and children leaving State custody for six months post-custody as long as the children remain eligible.
- Children receiving care in a Nursing Facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Children and adults currently enrolled in an HCBS ID waiver may opt in to receive services through TennCare Select, and new participants may opt out of TennCare Select in order to receive services through a different MCO.
- Enrollees living in areas where there is insufficient capacity to serve them. The state considers this group to include members of the former certified class in the *United States v the State of Tennessee* (Docket No. 92-CV-2062-JPM (W.D. Tenn.)) (the former “Arlington” class) who were transitioned from the Community Services Network pursuant to court order entered October 27, 2009. Additionally, the state considers that, effective April 1, 2015, this group includes persons who are incarcerated and who eligibility is therefore suspended. Covered services for incarcerated persons are limited to inpatient hospitalizations that last longer than 24 hours.
- Enrollees temporarily living out of state.

SSI-eligible children and children in NFs or ICFs/IID may opt out of TennCare Select if they wish and choose another TennCare MCO. Enrollees in other groups must remain in TennCare Select even if they desire to choose another MCO. Additional information about TennCare Select is found in Section 4.1.2.

Reference: See STC # 38 and TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.

2.5.3 Procedures for Enrollment with the Dental Benefits Manager (DBM) and/or the Pharmacy Benefits Manager (PBM)

Currently, there is only one DBM and one PBM, and the State enrolls members who have dental and/or pharmacy benefits with these contractors.

Reference: See STC # 37 (Enrollment in Managed Care Organizations (MCOs)), and TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.

2.5.4 Procedures for Changing MCOs

Enrollees are given their choice of health plans when possible. Once enrolled in an MCO, a new enrollee may change MCOs (if an alternate plan is available) within the first 45 calendar days (inclusive of mail time) from the date of the letter of enrollment and MCO assignment. An enrollee shall remain a member of the designated plan until he is given an opportunity to

change MCOs during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. An MCO change is only permitted outside of the annual change period if the Bureau authorizes a change as a result of an approved hardship request, or if the enrollee moves out of the area served by his MCO.

When an enrollee requests to change his MCO, the MCC Change Unit within the Division of Member Services reviews the change request against the six "hardship criteria" (see Attachment E). If the six criteria are not met, a denial letter is issued, which includes notice of the enrollee's right to appeal the denial of his request.

After requesting and obtaining the approval of the Bureau, enrollees may be permitted to change enrollment to a different health plan. In the event an enrollee changes plans, the enrollee's medical care will be the responsibility of the original health plan until the date that the new MCO assignment is effective.

In the event an MCO withdraws from participation in the TennCare program and is no longer available, the Bureau will randomly distribute its membership across the remaining plans. If an enrollee is not satisfied with the MCO that was randomly selected for him, the enrollee will have 45 calendar days (inclusive of mail time) from the date of the MCO assignment to change MCOs.

According to STC # 39, the following situations are not considered "hardships" for which an MCO transfer will be approved:

- The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as defined by the State);
- The enrollee claims lack of access to services but the MCO meets the State's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may use choice of providers, regardless of network providers; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCC's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

Reference: See STC # 39 (Plan Enrollment and Disenrollment) and TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.

2.5.5 Procedures for Annual Notification of Members

In keeping with the notice requirements outlined in the federal managed care regulations at 42 C.F.R. § 438.10(f) and in their TennCare Contractor Risk Agreements (CRAs), the MCOs are required to update and mail member handbooks annually to those enrolled in their plans.

Section 2.6

Enrollee Marketing and Outreach Strategy

TennCare’s MCO Contractor Risk Agreements (CRAs) prohibit marketing activities that promote the MCO, or that would be perceived as intended to influence an individual to enroll in that MCO, or not to enroll in or to disenroll from, another MCO. The prohibition on enrollee marketing does not apply to health education and outreach activities that have received prior approval in writing from the Bureau.

2.6.1 Marketing Activities and Restrictions

Marketing guidelines are included in the CRAs. Key points are summarized below.

Each MCO must submit a detailed marketing plan, all marketing materials, and a description of marketing activities to the Bureau for review and approval prior to implementation or use. All written marketing materials must be worded at a reading level that does not exceed sixth grade and must be printed with a minimum font size of 12 points. Materials must be made available in English, Spanish, and in the language of any other LEP group identified by the Bureau as constituting five percent of the TennCare program population or 1,000 enrollees, whichever is less.

Written materials must be made available in alternative formats and appropriate interpretation services must be provided for persons with special needs.

MCOs are permitted to distribute approved material through mass media and through general activities that benefit the entire community, such as health fairs. Telephone calls, mailings or home visits to current enrollees are permitted only for the purpose of educating current enrollees about services offered by the MCO.

The following activities are prohibited:

- Use of materials or activities that mislead, confuse, defraud, or are unfair;
- Use of overly aggressive solicitation;
- Gifts and offers of material or financial gain as incentives to enroll;
- Compensation arrangements with marketing personnel that tie compensation to the number of persons enrolled;
- Direct solicitation of prospective enrollees; or,
- Use of independent marketing agents.

2.6.2 Monitoring of Enrollee Marketing Activities

The primary focus of monitoring marketing activities is to assure that materials are clearly written and include content that is both correct and appropriate. The Bureau also permits MCOs to conduct various outreach activities, like health fairs. Plans for these activities also require the Bureau’s approval as part of marketing oversight. If complaints are reported by applicants or

enrollees, additional monitoring activities may include member surveys, random audits, or undercover observation of marketing activities.

2.6.2.1 Review and approval of enrollee marketing plans and activities

As set forth in their CRAs, MCCs must submit detailed descriptions of all proposed marketing activities as well as copies of all marketing materials to be used. These include: advertisement copy; brochures; posters; fact sheets; video media; story boards for production of videos; audio media; newsletters; telemarketing scripts; and any other forms of advertisement as well as other forms of public contact such as participation in health fairs.

The marketing plans and materials are reviewed to ensure that proposed activities are permitted under state and federal marketing guidelines. The Bureau will approve, deny, or return the plan with comments within 15 days. Once approved marketing materials have been produced, copies of the final product must be submitted to the Bureau.

2.6.2.2 Failure to adhere to contractual marketing guidelines

If the Bureau believes that violations of the marketing guidelines have occurred, an informal investigation will be conducted and the Bureau will determine the appropriate response. This response may include written warnings to the MCC or initiation of corrective action.

MCCs are required to develop and implement corrective actions to remedy any identified marketing problem(s). Sanctions may be imposed until such time as the State is satisfied that a problem has been resolved.

Chapter 3:

Benefits and Cost-Sharing



TennCare II Operational Protocol

Section 3.1 Benefits

3.1.1 TennCare Benefits

The benefits available to TennCare program enrollees are listed in the TennCare Rules for TennCare Medicaid and TennCare Standard, and are available on the Bureau's website. Definitions of specific services included, and services that are excluded, from coverage are also listed in the rules. These rules should be consulted for information on particular limitations and coverage details.

Reference: See TennCare Rules 1200-13-13-.04 and 1200-13-14-.04 (Covered Services) and TennCare Rules 1200-13-13-.10 and 1200-13-14-.10 (Exclusions). TennCare benefits are also discussed at STC # 28 (TennCare Benefits).

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

- Community health services
- Dental services (for children under age 21)
- Durable medical equipment
- Emergency air and ground transportation services
- EPSDT services for TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21
- Home health services
- Hospice care
- Inpatient and outpatient substance abuse benefits
- Inpatient hospital services
- Lab & X-ray services
- Medical supplies
- Mental health case management
- Mental health crisis services
- Non-emergency transportation services
- Occupational therapy
- Organ and tissue transplant services and donor organ/tissue procurement services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy services
- Physical therapy services
- Physician services
- Private duty nursing services¹⁶

¹⁶ Private duty nursing services for adults are covered only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision,

- Psychiatric inpatient facility services
- Psychiatric rehabilitation services
- Reconstructive breast surgery
- Renal dialysis clinic services
- Speech therapy services
- Vision services (for children under age 21)

In addition, any benefits that are coverable under Medicaid are provided for children under 21 as medically necessary.

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

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

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

Reference: See STCs # 28 (TennCare Benefits) & # 29 (Cost-Effective Alternatives)

3.1.2 Benefits for Dual Eligibles

Dual eligibles are Medicare beneficiaries who are also eligible for some form of assistance from the TennCare program. A list of the categories of dual eligibles and a description of each category are presented in Section 2.1.4.

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

visual assessment, and monitoring of both equipment and patient are required. See TennCare Medicaid Rule 1200-13-13-.01 and TennCare Standard Rule 1200-13-14-.01.

Table 3-1: TennCare Benefits for Dual Eligibles

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

3.1.3 TennCare CHOICES Benefits

Under the CHOICES program, the Bureau provides physical, behavioral and substance abuse, and long-term services and supports benefits through its managed care delivery systems. Table 3-2 below lists the NF and HCBS benefits for TennCare Medicaid enrollees and CHOICES Demonstration eligibles who are enrolled in the designated CHOICES groups. (See Section 2.1.3 for descriptions of the CHOICES groups.)

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

- The total cost of a CHOICES 2 member’s HCBS, HH services, and PDN services may not exceed the member’s cost neutrality cap, which cannot be more than the average cost of the level of NF reimbursement that would be paid if the member were institutionalized.
- For persons in CHOICES 3 or Interim CHOICES 3, there is a limit of \$15,000 in CHOICES HCBS that is available in a given calendar year. This limit does not include the costs of Minor Home Modifications.
- For purposes of determining capitation rates, the cost of room and board, as defined in the Special Terms and Conditions (STCs) and TennCare Rule 1200-13-01-.02, is not included in non-institutional care costs.
- Definitions for CHOICES benefits (and other CHOICES-related terms) are found in Attachment D to the waiver STCs and TennCare Rule 1200-13-01-.02.

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

Benefit	CHOICES 1	CHOICES 2	CHOICES 3¹⁷
Nursing facility care	X	Short-term Only	Short-term Only
Community-based residential alternatives		X	
Personal care visits (up to 2 visits per day)		X	X
Attendant care (up to 1,080 hours per calendar year)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2,080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X

¹⁷ CHOICES HCBS for persons in CHOICES Group 3 (including Interim CHOICES Group 3) are limited to \$15,000 per Calendar Year, excluding Minor Home Modifications.

Benefit	CHOICES 1	CHOICES 2	CHOICES 3¹⁷
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

See STC # 28(h) Table 2b (Benefits for Persons Enrolled in the CHOICES Program)

Section 3.2 TennCare Cost-Sharing

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

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

Copays. Certain enrollees have copay obligations for selected services. Most of these copays are calculated based on the enrollee's income, which is verified by the Bureau at the time the individual applies for TennCare program benefits, and any time an enrollee's income changes.¹⁸

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

TennCare Standard children whose income is 100% FPL and above have a quarterly aggregate cost cap of 5% of the family income. This means that at any time during a quarter when members of the family have incurred enough TennCare copays to equal 5% of the family's income (as calculated for the quarter), there will be no more copays required for any members of the family for the remainder of that quarter.

Additional information about enrollee copays can be found in Sections 3.2.1 and 3.2.2 below and in the TennCare rules.

Exempt and non-exempt enrollees. Certain enrollees are exempt from copays. These include the following:

- Enrollees who are receiving hospice services and who provide notification of such to the provider at the point of service
- Enrollees who are pregnant and who provide notification of such to the provider at the point of service
- Enrollees who are receiving services in CHOICES 1 or 2, PACE, Intermediate Care Facilities for Individuals with Intellectual Disabilities, or HCBS waivers
- Children under age 21 who are enrolled in TennCare Medicaid
- Children under age 21 who are enrolled in TennCare Standard and who have family incomes below 100% of poverty

Enrollees who are subject to copays are called "non-exempt" enrollees.

¹⁸ Enrollees must report any changes in income to TennCare(at the time such change occurs. Information about documentation to be supplied and the reporting of changes is provided in T.C.A. § 71-5-110.

Exempt and non-exempt services. There are some services for which no copays are required. These are called “exempt services.” Other services are called “non-exempt services.” The following services are exempt from copays for all TennCare program enrollees:

- Emergency services
- Family planning services and supplies
- Preventive services identified in TennCare Rules 1200-13-14-.04

Reference: See TennCare Rules 1200-13-13-.05 and 1200-13-14-.05 and STCs # 33 (Cost Sharing) and # 34 (Co-payments).

3.2.1 Pharmacy Copays

A pharmacy copay of \$3.00 for brand name drugs and a copay of \$1.50 for generic drugs apply to the following populations:

- TennCare Standard children with household incomes at or above 100% of poverty
- TennCare Standard enrollees in the Standard Spend Down program
- TennCare Standard enrollees in the CHOICES At Risk Demonstration Group
- Non-exempt TennCare Medicaid adults (age 21 and older)

No pharmacy copay is required for the seventy-two (72) hour emergency supply of a medication in an emergency situation.

Reference: STC # 34 (Copayments) and TennCare Medicaid Rules 1200-13-13-.01& 1200-13-13-.05 and TennCare Standard Rules 1200-13-14-.05 & 1200-13-14-.11.

3.2.2 Non-Pharmacy Copays

Non-pharmacy copays apply to TennCare Standard children under age 21 whose income is equal to or greater than 100% of poverty. These copays are presented in Table 3-3.

Table 3–3: Current TennCare Standard Non-Pharmacy Copay Schedule

Service	Income Level of 100% to 199% of Poverty	Income Level of 200% of Poverty and above
Hospital emergency room service (non-emergency service; copay waived if admitted)	\$10	\$50
Primary care provider services other than preventive care	\$5	\$15
Community Mental Health Agency services other than preventive care	\$5	\$15
Physician specialists (including psychiatrists and dentists)	\$5	\$20
Inpatient hospital admissions (copay waived if enrollee is readmitted within 48 hours for the same episode)	\$5	\$100

Reference: STC # 34 (Co-payments) and TennCare Standard Rule 1200-13-14-.05.

3.2.3 Seeking Payment from a TennCare Enrollee

As a general rule of thumb, applicable copayments are the only payments that providers can accept from TennCare program enrollees. One of the conditions of provider participation in the TennCare program is acceptance of the MCC payment amounts as payment in full.

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

TennCare Rules 1200-13-13-.08(6) and 1200-13-14-.08(6) outline the limited circumstances in which providers may seek payment from an enrollee.

References: See TennCare Rules 1200-13-13-.08(5) & (6) and 1200-13-14-.08(5) & (6).

Policy Statement: PRO 08-001 – When a Provider May Bill a TennCare

Enrollee <http://www.tn.gov/tenncare/pol-policies.html>

Section 3.3 TennCare and Third Party Insurance

3.3.1 Third Party Liability (TPL)

Some TennCare program enrollees have other insurance—known as “Third Party Liability” or TPL—which can be an important resource in paying for at least a portion of the services these enrollees receive. Recognition and capture of TPL are critical components in the Bureau’s efforts to use resources wisely and contain costs. State Medicaid programs, including TennCare, administer TPL programs to identify third parties liable for payment of Medicaid services and to pursue third party payment when such payment is available.

Every person who enrolls in the TennCare program automatically assigns his right to collect TPL to the "State" (TennCare), which has delegated this authority to the MCOs. When an enrollee has TPL, the provider must bill the third party before submitting a claim to the enrollee’s TennCare MCO. Providers must follow the third party’s requirements for obtaining payment (e.g., getting prior authorization) in addition to the requirements for submitting claims to the MCO. TennCare is always the payer of last resort, except in a few circumstances where federal law states otherwise.

References:

Policy Statements: CON 05-001 “MCCs’ and Providers’ Responsibility When Enrollees have Third Party Copays and/or Deductibles” and CON 09-001 “Third Party Liability.”

Both Policy Statements can be found at: <http://www.tn.gov/tenncare/pol-policies.html>

MCO Contractor Risk Agreement, Sec. 2.21.4

3.3.2 Subrogation

When an insurance company or another person owes money to a TennCare program enrollee because of an injury or illness, Federal and State law provides that the State, through the Bureau and/or its MCOs, is "...subrogated to all rights of recovery, for the cost of care or treatment for the injury or illness for which medical assistance is provided. . ." This means that if the Bureau and/or one of its MCOs paid for a service, and the enrollee later receives a payment related to the injury or illness, the Bureau or the MCO has the right to recover the money it paid from the enrollee.

See <http://www.tn.gov/tenncare/subrogation.html> for more information.

Chapter 4:

Service Delivery



TennCare II Operational Protocol

Section 4.1

Overview of Managed Care Entities

4.1.1 Managed Care Organizations (MCOs) other than TennCare Select

All TennCare program enrollees receive their physical health services, mental health and substance abuse services, and most long-term services and supports from their MCOs. MCOs are required by contract to maintain adequate provider networks and meet provider access standards, specific examples of which are listed below:

- MCOs must contract with at least two Centers of Excellence (COEs) for people with HIV/AIDS in each Grand Division;
- MCOs must have contractual arrangements with all COEs for Behavioral Health located within each Grand Division;
- MCOs must provide adequate numbers of specialty providers (specialists) for the provision of covered services to ensure adequate provider availability for their non-dual members. MCOs are encouraged to contract with FQHCs, Community Mental Health Agencies (CMHAs) and other safety net providers (e.g., rural health clinics) in each service area to the extent possible and practical. Where FQHCs and CMHAs are not used, MCOs must demonstrate that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in each service area; and
- MCOs must contract with all local health departments in each Grand Division for the provision of TENNderCare screening services.

MCOs must also maintain case management programs to ensure that enrollees receive all necessary services on a timely basis.

4.1.2 TennCare Select

TennCare Select is the State's self-insured health plan administered by Volunteer State Health Plan. TennCare Select currently serves the following populations:

- Children who are eligible for Supplemental Security Income (SSI);
- Children in State custody and children leaving State custody for six months post-custody, as long as the child remains eligible;
- Children who are receiving care in a Nursing Facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual

disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO;

- Enrollees living in areas where there is insufficient capacity to serve them;
- Enrollees temporarily absent from the state, or receiving services out-of-state, in accordance with 42 CFR 431.52; and
- Undocumented aliens who meet TennCare eligibility criteria and whose emergency services are paid for by TennCare in accordance with 42 CFR 440.255(c).

TennCare Select also functions as the back-up plan should one of the MCOs leave the TennCare program unexpectedly. The State reserves the right to add groups to TennCare Select as needed.

All TennCare Select members are assigned to a Primary Care Provider (PCP) who is responsible for providing, or coordinating, covered health care services to the enrollee. TennCare Select members are not required to get referrals from their PCPs for behavioral health services.

Reference: See TennCare Rules 1200-13-13-.03 and 1200-13-14-.03 and STC # 38 (TennCare Select).

4.1.3 Dental Benefits Manager

TennCare program enrollees under 21 years of age are assigned to the DBM under contract with the Bureau in order to receive covered dental benefits, including preventative, diagnostic, and treatment services, as medically necessary. Orthodontia services may also be provided to treat a handicapping malocclusion if prior authorization is received from the DBM and the treatment meets the criteria outlined in TennCare policy. TennCare program enrollees age 21 and older are not eligible for dental benefits.

Reference: See TennCare Rules 1200-13-13-.04 and 1200-13-14-.04, and TennCare Policy PRO 05-001: Orthodontia Providers

4.1.4 Pharmacy Benefits Manager

TennCare program enrollees who are eligible to receive pharmacy services are assigned to the PBM under contract with the Bureau in order to receive pharmacy benefits for both medical and behavioral health services. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in doctor's office which are the responsibility of the enrollee's MCO. Enrollees who are dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D.

Reference: See TennCare Rules 1200-13-13-.05 and 1200-13-14-.05

4.1.5 Other State Agencies

4.1.5.1 Department of Intellectual and Developmental Disabilities (DIDD)

The Bureau has established a contractual relationship with DIDD, delegating to the agency the responsibility for daily operations of HCBS waiver programs for individuals with intellectual disabilities—the Arlington Waiver, the Self-Determination Waiver, and the Statewide Waiver. Under the contract, DIDD is responsible for the following administrative and operational functions:

- Management of a qualified provider network sufficient to assure accessibility to services,
- Development and implementation of approved policies and procedures,
- Management of the intake, enrollment, and waiting list processes,
- Approval of individual support plans and prior authorization of services,
- Provider reimbursement for services,
- Provision of training and technical assistance to providers,
- Implementation of a quality management program to ensure appropriate provision of services,
- Monitoring activities to determine provider compliance with approved rules, regulations, and policies,
- Implementation of grievance and appeals procedures for both program participants and providers, and
- Provision of informational materials to providers, individuals receiving services and their families, potential applicants for services, and other interested stakeholders.

Reference: DIDD Provider Manual, Section IN.7

4.1.5.2 Department of Children’s Services (DCS)

The Bureau has established a contractual relationship with DCS to provide certain medical and Medicaid administrative services to children in, or at risk of, DCS custody. Under the contract, DCS is responsible for the following administrative and operational functions:

- Provide the determination of eligibility for the TennCare Medicaid services, including EPSDT
- Provision of, or arranging for the provision of, Title V health services to both TennCare and Title V Program eligible children, including targeted case management
- Provision of children’s therapeutic intervention services as all, or part of, DCS residential placement or continuum services
- Assure DCS’s provider networks are adequate for the provision of services which are the agency’s responsibility

Additionally, TennCare has authorized DCS to provide administrative services for the state’s five Behavioral Health Services Centers of Excellence (COE). The COEs provide direct services to children who have complex behavioral and medical problems and who are currently, or at risk of being placed, in state custody. Services include psychiatric and psychological evaluations, medication management, development and review of treatment plans, case consultation and coordination with DCS and TennCare providers, and coordination of referrals for additional medical and behavioral health services.

Section 4.2

Organization of Managed Care Networks

4.2.1 Grand Divisions

Grand Divisions are the three geographical regions into which the State of Tennessee is divided: East Tennessee, Middle Tennessee, and West Tennessee (See *T.C.A. § 4-1-201*). MCOs wishing to participate in the TennCare program must cover all three geographical grand divisions.



WESTERN GRAND DIVISION	MIDDLE GRAND DIVISION	EASTERN GRAND DIVISION
Benton	Bedford	Anderson
Carroll	Cannon	Bledsoe
Chester	Cheatham	Blount
Crockett	Clay	Bradley
Decatur	Coffee	Campbell
Dyer	Cumberland	Carter
Fayette	Davidson	Claiborne
Gibson	DeKalb	Cocke
Hardeman	Dickson	Franklin
Hardin	Fentress	Grainger
Haywood	Giles	Greene
Henderson	Hickman	Grundy
Henry	Houston	Hamblen
Lake	Humphreys	Hamilton
Lauderdale	Jackson	Hancock
Madison	Lawrence	Hawkins
McNairy	Lewis	Jefferson
Obion	Lincoln	Johnson
Shelby	Macon	Knox
Tipton	Marshall	Loudon
Weakley	Maury	Marion
	Montgomery	McMinn
	Moore	Meigs
	Overton	Monroe
	Perry	Morgan
	Pickett	Polk
	Putnam	Rhea
	Robertson	Roane
	Rutherford	Scott
	Smith	Sequatchie
	Stewart	Sevier
	Sumner	Sullivan
	Trousdale	Unicoi
	Van Buren	Union
	Warren	Washington
	Wayne	
	White	
	Williamson	
	Wilson	

4.2.2 Selection and Contracting Process

MCOs are selected for participation in the TennCare Demonstration through a competitive bid process. MCOs must meet all of the qualifications established in the TennCare Contractor Risk Agreement (CRA). Included in these qualifications are the following:

- Appropriate licensure as an HMO by the Tennessee Department of Commerce and Insurance;
- Demonstration of adequate financial capacity to take on risk for all contracted services and enrollees;
- Demonstration of an adequate provider network to deliver all contracted services to all enrollees in the plan in accordance with time/distance/location/patient volume standards established by TennCare;
- Demonstration of ability to offer electronic billing to providers, to comply with prompt pay processing requirements, and to use standard billing forms and formats as required by TennCare and TDCI;
- Demonstration of ability to adhere to all quality health standards, including preventive health standards, established by TennCare; and
- Demonstration of ability to report provider-related data using a uniform provider number, as established by TennCare.

For participating MCOs, the contracting process is ongoing. Contracts are amended, renegotiated, and/or terminated in accordance with the terms outlined in the contract.

The list of current Managed Care Contractors is found in Attachment D.

4.2.3 Network Requirements

Attachment G of this document contains the access standards MCOs are required to follow to ensure TennCare enrollees' timely access to health care. This Attachment addresses both primary care and specialty care.

4.2.4 Mailing of Identification Cards

MCOs are required to provide individual identification cards to all their members to identify them as enrollees in their plan. Identification cards must be approved in writing by the State. The cards must comply with all State and Federal requirements. MCOs shall provide an identification card to the enrollee identifying him as a participant in the TennCare program, within 30 calendar days of the enrollee receiving notification of his MCO assignment.

4.2.5 Member Service and Clinical Performance Standards

MCOs are required to operate a toll-free member services information line to respond to questions and concerns from the member, the member's family, or the member's provider. MCOs must adequately staff the member services information line and meet specified performance standards, such as the percent of calls answered within a specified timeframe or average wait times for assistance.

MCOs are required to report annually on performance indicators using the Consumer Assessment of Healthcare Providers (CAHPS) and the Healthcare Effectiveness Data and Information Set (HEDIS). These results are compared to national norms and tracked over time to evaluate the effectiveness of quality improvement efforts. CAHPS surveys assess member satisfaction with various health care experiences, such as provider communication and access to services. Separate results must be reported by the MCOs for the CAHPS adult survey, CAHPS child survey, and CAHPS children with chronic conditions survey.

HEDIS data measures a health plan's performance on specially defined indicators across multiple domains of care and service. Selected HEDIS measures are described below in order to provide examples of the types of indicators that are reported.

- The percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B; one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates (target: 100%);
- The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer (meeting the guidelines of the American College of Obstetricians and Gynecologists);
- The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer (meeting the guidelines of the American College of Obstetricians and Gynecologists);
- The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following (target: at least one test per year):
 - HbA1c testing
 - HbA1c poor control (>9.0%)
 - HbA1c good control (<7.0%)
 - Eye exam (retinal or dilated) for diabetic retinal disease performed
 - LDL-C screening performed
 - LCL-C control (<100mg.dL)
 - Medical attention for nephropathy
 - Blood pressure control (<140/90 mm Hg)

- Blood pressure control (<130/80 mm Hg)
- Children 12-24 months and 25 months-6 years who had a visit with an MCO primary care practitioner during the measurement year (target: 100%);
- Children 7-11 and adolescents 12-19 years who had a visit with an MCO primary care practitioner during the measurement year or the year prior to the measurement year (target: 100%);
- The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (target: 100%).

Reference:

Additional information about the Healthcare Effectiveness Data and Information Set (HEDIS) standards can be found on the National Committee for Quality Assurance's (NCQA) website at <http://www.ncqa.org/tabid/59/Default.aspx>

CAHPS is a public-private initiative to develop standardized surveys of patients' experience with ambulatory and facility level care. Information about CAHPS can be found on the Agency for Healthcare Research and Quality's (AHRQ) website at: <https://www.cahps.ahrq.gov/default.asp>

4.2.6 PCP Selection and Assignment

MCOs ensure that each TennCare program member has an assigned PCP who is responsible for providing preventative and primary health care, coordinating the member's covered services, and maintaining the member's medical records. PCPs may include licensed physicians, as well as Advanced Practice Nurses and Physician Assistants, in accordance with State law.

To the extent feasible and appropriate, all non-dual members will be given the opportunity to select a PCP. (Dual members do not need to select a TennCare PCP, since they get most of their physician services through Medicare physicians.) At its discretion, the MCO may allow vulnerable populations—such as persons with multiple disabilities, acute, or chronic conditions—to select their attending specialist as their PCP, so long as the specialist is willing to perform all responsibilities required of a PCP. If the member fails or refuses to select a PCP within thirty (30) calendar days of enrollment, the MCO will assign a PCP. The MCO may assign a PCP in less than thirty (30) calendar days, if the member is provided an opportunity to change PCPs upon receipt of notice of assignment.

MCOs ensure that members have reasonable opportunities to change PCPs. The MCOs policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If an MCOs policies and procedures limit the member's ability to change PCPs, provisions must be included for more frequent PCP changes, with good cause.

Reference: See MCO Contractor Risk Agreement Section 2.11.2

4.2.7 Best Practice Network (BPN) for Children in State Custody

The Best Practice Network (BPN) is composed of Best Practice Providers (BPPs) who are involved in the medical care of children in State custody. A Best Practice Provider is a health care provider (either a primary care provider, provider of behavioral health services, or a dental provider) who has been determined by the State to have the interest, commitment, and competence to provide appropriate care for children in State custody—in accordance with statewide Best Practice Guidelines—and who has agreed to be in the MCO network. The BPN is currently a sub-network of TennCare Select providers. The assigned BPP agrees to maintain a medical home for all of the child’s health records, regardless of where the care is provided. All providers are required to forward medical records to the BPP so that a comprehensive medical record can be maintained.

4.2.8 MCO Claims Systems and Performance Standards

MCOs are required to maintain a claims management system capable of accepting and processing claims submitted electronically—with the exception of certain claims that require written justification for payment, such as hysterectomy consent forms—as well as tracking and reporting service use against benefit limits.

MCOs must comply with prompt pay claims processing requirements, in accordance with *T.C.A. § 56-32-126*, assuring that 90 percent of clean claims for payment of services delivered to a TennCare enrollee are paid within thirty (30) days of receipt. (A clean claim is defined as one for which no further written information or substantiation is required in order to make a decision on payment.) In addition, the MCO must assure that it will process, and pay if appropriate, 99.5 percent of claims for covered services within 60 days of receipt. The MCO must also assure that 90 percent of clean claims for nursing facility services and CHOICES HCBS (excluding PERS, assistive technology, minor home modifications, and pest control) within 14 days of receipt, and 99.5 percent within 21 days of receipt.

MCOs are required to have an internal claims dispute procedure that has been approved by the Bureau, and to contract with independent reviewers to review disputed claims in accordance with *T.C.A. § 56-32-126*.

MCOs are required to measure their claims payment accuracy, based upon the number of claims paid accurately upon initial submission, by provider type. The target is 100 percent, with a benchmark of 97 percent accuracy upon initial submission.

Reference: See T.C.A. § 56-32-126.

The following Policy Statements, found on the TennCare website, provide additional information:

PAY 06-002 – Claims Processing Relating to Timely Filing and Prior Authorizations

PAY 08-001 – Addressing Issues Affecting the Actuarial Soundness of TennCare Rates

<http://www.tn.gov/tenncare/pol-policies.html>

Section 4.3 Payment Mechanisms

4.3.1 MCC Reimbursement Methodology

4.3.1.1 Managed Care Organizations (MCOs)

Full risk arrangements. At present, all MCOs (other than TennCare Select) participate are reimbursed on a per-member/per-month (PMPM) capitation basis for the provision of medical services, behavioral health and substance abuse services, and long-term services and supports through their integrated services contract. The rates vary by age and eligibility category.

Shared risk arrangements. The TennCare Select contractor participates is reimbursed on a non-capitated basis for services rendered to covered populations and receives fees from the State to cover administrative costs.

Reimbursement of actual expenses for medical care delivered to TennCare Select enrollees is made on a weekly basis, while administrative fee payments are made monthly. A portion of TennCare Select's administrative payment is placed at risk. The terms of this financial arrangement, which is part of TennCare Select's contract, include a Risk and Bonus component, placing 10 percent (10%) of the administrative fee at risk and providing a Bonus potential to earn 10 percent (10%) of the administrative fee for maintaining and/or meeting specified performance measures. The performance measures and percentages of Risk and Bonus associated with each are listed below:

Shared Risk Initiative	Contribution to Risk	Contribution to Bonus
Medical Services Budget Target	5.0%	5.0%
EPSDT Compliance	5.0%	5.0%

Reference: For additional information about TennCare rates, see Policy Statement PAY 08-001 "Addressing Issues Affecting the Actuarial Soundness of TennCare Rates" <http://www.tn.gov/tenncare/pol-policies.html>

4.3.1.2 Dental Benefits Manager (DBM)

Payments to the DBM fall into two categories: Administrative and Medical Reimbursement. Administrative payments are made monthly based on a contracted amount PMPM. Reimbursement of actual dental expenses incurred by TennCare enrollees is made on a biweekly basis.

4.3.1.3 Pharmacy Benefits Manager (PBM)

Payments to the PBM fall into one of the following categories: Administrative, Prescription, Implementation, or Call Center.

Monthly payments made pursuant to the Administrative category are based on fixed amounts for various administrative functions. Payments in the Prescription category are made monthly based on actual costs for prescriptions issued to TennCare enrollees. Payments in the Implementation category are made monthly based on specific milestones within the PBM contract. The last category, Call Center, is for payments made to the PBM based on call center volume.

4.3.2 Payment Methodologies for Other Selected Providers

4.3.2.1 Federally Qualified Health Centers reimbursement methodology

Because FQHCs provide health care to underserved populations, often on a sliding scale, the federal government requires that FQHCs receive special reimbursement from state Medicaid programs. In Tennessee, the State provides FQHCs with quarterly payments recognizing the difference between the payments these entities receive from the MCOs and the FQHCs' payment rate. Within 60 days after the end of each quarter, FQHCs report the number of actual visits and the corresponding MCO payments for services provided to TennCare enrollees. Upon review of these reports by the Comptroller's Office, the State makes quarterly payments to the FQHCs for the actual difference between the amount of MCO reimbursements received and the adjusted prospective payment rate for the FQHCs. In the event an FQHC does not timely report the number of visits and MCO payments received for the quarter, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter are received.

4.3.2.2 Supplemental Payment Pools

The Bureau makes supplemental payments to health care providers and entities that accumulate increased uncompensated or unreimbursed costs due to providing services in rural and/or low-income areas. Under the TennCare waiver, several payment pools have been approved for federal reimbursement of these funds, as follows:

- Essential Access Hospital (EAH) Payments- Provides cash payments of up to \$25 million quarterly for uncompensated care costs at high-volume and charity hospitals that serve a disproportionate number of low-income patients with special needs.
- Disproportionate Share (DSH) Payments- An allotment in effect at one time, established for Tennessee in FY 2007 by the Tax Relief and Health Care Act of 2006, for payments made to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Hospitals will receive payments that vary according to the group in which they are categorized, and factors such as TennCare program volume and bad debt, charity, and medically indigent care.
- Critical Access Hospital (CAH) Payments- Provides cash payments of up to \$10 million per demonstration year for uncompensated care costs at facilities designated as a CAH by the DOH. CAHs are typically small, rural hospitals that provide access to primary and emergency care low-income patients in rural areas who have special needs.

- Meharry Medical College Payments- Provides cash payments of up to \$10 million per demonstration year for uncompensated care costs of the two Medicaid clinics operated by Meharry Medical College.
- Unreimbursed Public Hospital Costs for Certified Public Expenditures (CPEs)- Payments made to government operated hospitals for unreimbursed costs related to the provision of inpatient and outpatients services for TennCare enrollees and uninsured patients.
- Unreimbursed Hospital Cost Payments (UHC)- Payments made to eligible Tennessee hospitals for costs that are unreimbursed by TennCare. The total amount of UHC payments will be determined annually, and may not exceed \$500 million per demonstration year.
- Public Hospital Supplemental Payments (PHSP)- Provides cash disbursements up to \$100 million per demonstration year to selected public hospitals for uncompensated care costs for services provided to TennCare enrollees and uninsured patients. Payments may be made to the following hospitals:
 - Regional Medical Center at Memphis,
 - Nashville General Hospital at Meharry, and
 - Erlanger Hospital in Chattanooga.

Chapter 5:

Quality of Care



TennCare II Operational Protocol

Section 5.1 Evaluation Design

5.1.1 Program Objectives

The purpose of the TennCare Demonstration is to establish that careful use of a managed care approach can enable the State to deliver quality care to all enrollees with spending more than if the State continued its Medicaid program.

Part II (“Program Description and Objectives”) of the Special Terms and Conditions (STCs) lists seven objectives of the TennCare program. These objectives are:

- Use a managed care approach to provide services to Medicaid State Plan and Demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program
- Assure appropriate access to care for enrollees
- Provide quality of care to enrollees
- Assure enrollees’ satisfaction with services
- Improve health care for program enrollees
- Assure that participating health plans maintain stability and viability while meeting all contract and program requirements
- Provide appropriate and cost-effective home and community based services (HCBS) that will improve the quality of life for persons who qualify for Nursing Facility (NF) care, as well as for persons who do not qualify for NF care but who are “at risk” of institutional placement and that will help to rebalance long-term services and supports expenditures.

5.1.2 Summary of Evaluation Plan

STC # 66 requires the Bureau to file a draft Evaluation Plan within 120 days following CMS’s approval of the Demonstration extension. This draft Evaluation Plan, approved by CMS on March 31, 2008, describes Performance Measures for each of the program objectives listed above. The Bureau reports on information about the evaluation in the CMS Annual Report filed pursuant to STC # 46.

Section 5.2

Quality Assurance

5.2.1 MCO Quality Monitoring

The Division of Quality Oversight is responsible for monitoring and ensuring that enrollees have access to timely, appropriate, high quality, medically necessary, covered healthcare services and experience quality health outcomes. Monitoring activities are provided either directly by Quality Oversight or in concert with TennCare contractors.

The Bureau has mandated that all Managed Care Organizations (MCOs) participating in the TennCare Demonstration be accredited by the National Committee for Quality Assurance (NCQA). [Tennessee was the first State in the nation to require all of its MCOs to be NCQA-accredited.] New MCOs must be NCQA-accredited by a date specified in their contracts. NCQA accreditation was selected because the accreditation survey process encompasses a comprehensive review of the key aspects of care and service and the overall quality of care provided by individual MCOs. The contracts of MCOs failing to obtain or maintain NCQA accreditation will be terminated by the Bureau, leaving only those MCOs providing the highest quality of care and service to serve the TennCare population.

As part of the accreditation process, the MCOs perform the Medicaid version of HEDIS and CAHPS. HEDIS and CAHPS allow a reliable comparison of the performance of TennCare MCOs to other Medicaid managed care health plans.

HEDIS data are audited by an NCQA-certified HEDIS auditor prior to submission to the Bureau and the NCQA. Analysis of data allows the Bureau to assess MCO-specific performances and perform comparative analyses of the TennCare program to other Medicaid managed care plans throughout the country, as well as to each other. These data are used to identify best practices and determine opportunities for improvement among the TennCare MCOs. MCOs are also incentivized through a system of quality improvement in which plans are paid for significant gains (using NCQA methodology) in selected performance measures.

The CAHPS survey tool measures health care consumers' satisfaction with the quality of care and customer service provided by their health plans. Audited HEDIS and CAHPS data must be submitted to the Bureau annually for review and analysis. MCOs are required to report NCQA accreditation findings, level of accreditation awarded by NCQA, and any changes in accreditation status to the Bureau.

In addition to these standardized processes, the MCOs are monitored through rigorous reporting, site visits, conference calls, and meetings with various staff groups from the MCOs. Services monitored include quality improvement/utilization management, population health, complex case management, care coordination for long-term services and supports enrollees, performance improvement projects, EPSDT outreach, clinical practice guidelines, development and distribution of member materials, and emergency department utilization. An Annual Quality Survey, based on MCO contractual standards, is developed by the EQRO with the assistance of

the TennCare Quality Oversight staff. The information gathered through the survey is compiled and use by Quality Oversight to help determine needed areas of improvement.

5.2.2 Network Access

MCOs must ensure that there are an adequate number of primary care providers, specialists and other service providers who are willing and able to provide the level of care and range of services necessary to meet the needs of the enrollees in their Plans. The MCOs, as required by their contracts, must demonstrate their ability to provide all contracted services on a timely basis and assure accessibility to services. The Provider Networks Unit evaluates MCC provider networks on a routine basis, and, where non-compliance is indicated, a corrective action plan is requested and reviewed.

5.2.3 External Quality Review Organization (EQRO) Activities

The Bureau contracts with an EQRO to support independent, external reviews of the quality of services available to enrollees in the TennCare project. The EQRO assists the Bureau in reaching its goal of ensuring that each enrollee can access timely, high quality, medically necessary, covered healthcare services.

The EQRO provides services that are consistent with the following:

- Applicable Federal External Quality Review (EQR) regulations and protocols for Medicaid MCOs,
- State-specific requirements related to Federal court orders, including *Grier* and *Newberry*; and
- Requirements of Contractor Risk Agreements (CRAs) with TennCare MCCs, including the MCOs, the Dental Benefits Manager (DBM), and the Pharmacy Benefits Manager (PBM).

The EQRO Technical Report, required by CMS, summarizes the manner in which data from mandated external quality review activities were aggregated, analyzed, and conclusions drawn. Conclusions relate to the quality and timeliness of, and access to, care furnished to TennCare-enrolled recipients by its contracted MCOs and DBM. The three federally mandated activities – performed by the EQRO for the Bureau are: validation of performance measures, validation of performance improvement projects, and monitoring compliance with the federal and state standards.

5.2.4 EPSDT Focused Efforts

The State takes a number of steps to ensure that EPSDT screenings and services are provided appropriately. In accordance with their contracts, MCOs participating in the TennCare program must conduct effective outreach and education programs; provide transportation and scheduling assistance for each eligible child's periodic examination; and conduct extensive provider education.

EPSDT screens are to be provided in accordance with the latest “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care” periodicity schedule. Periodically, the Division of Quality Oversight monitors the MCOs’ performance with respect to the provision of EPSDT screens and a statistically valid sample of medical records is reviewed to measure whether the seven required components of the screen have been performed. MCOs are required to submit corrective action plans to address deficiencies found in any of the required screening components.

Specific performance targets have been established for EPSDT screens, and incentives have been included in the MCOs’ CRAs to encourage and maintain compliance with the performance targets.

Reference: American Academy of Pediatrics Recommendations for EPSDT Screens
<http://pediatrics.aappublications.org/cgi/content/full/105/3/645>

Section 5.3 Appeal Policies

5.3.1 Eligibility Appeals

TennCare enrollees may appeal adverse actions affecting their eligibility. An “adverse action” is defined as a termination, suspension or reduction of TennCare eligibility. Individuals applying for TennCare Medicaid on the FFM may appeal denials of their applications to the Office of Marketplace Eligibility Appeals (OMEA) or the TennCare Eligibility Appeals Unit.

The State has the responsibility, using a single administrative process, for both TennCare Medicaid and TennCare Standard eligibility-related appeals resulting from a termination, suspension, or reduction of benefits. The Bureau, as the administrative unit within the Single State Agency, retains the authority for final decision-making on appeals.

Based on approved processes and in accordance with applicable federal requirements, the Bureau has implemented the following structure for eligibility-related appeals:

- When an enrollee’s eligibility is terminated, suspended or reduced, he is provided at least 20 days advance notice. This notice informs the enrollee of (i) the reason for the action, (ii) the legal basis for the proposed action, (iii) the right to request a fair hearing, and (iv) the right to request continuation of benefits. An enrollee is provided 40 days from the date of the notice to request a fair hearing. An enrollee who requests a fair hearing prior to the date of action will retain his benefits pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
- When an individual’s application for the TennCare program is denied, he is provided notice. This notice informs the individual of (i) the reason for the denial, (ii) the legal basis for the denial, and (iii) the right to request a fair hearing. An individual is provided 40 days from the date of the notice to request a fair hearing.
- A request for a fair hearing is only granted to an individual who raises a valid factual dispute related to the action taken by the State. DHS is responsible for reviewing each request for a hearing to determine if it is based on a valid factual dispute. Upon determining that there is no valid factual dispute, DHS sends the individual a letter asking him to submit additional clarification of any issue of factual dispute on which the appeal is based within 10 days. Unless such clarification is timely received and is determined by DHS to establish a valid factual dispute, DHS dismisses the request for a fair hearing. If DHS determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.
- When an appeal is scheduled for a hearing, DHS provides the individual a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing; informs the individual of his right to be represented by counsel; cites the legal authority under which the hearing will be held; and provides a brief statement of the position

asserted by DHS. An individual may represent himself at the hearing or may retain someone to represent him at the hearing. Free or low-cost representation is often available from local Legal Services offices. DHS provides the individual with a list of all Legal Services offices throughout the State of Tennessee.

Reference: See TennCare Rules 1200-13-13-.12 and 1200-13-14-.12.

5.3.2 Service and Benefit Appeals

TennCare enrollees have the right to appeal adverse actions affecting their benefits. Adverse actions include, but are not limited to, delays, denials, reductions, suspensions, or terminations of TennCare benefits, as well as any other act or omission of the TennCare program that impairs the quality, timeliness or availability of such benefits. The Bureau is responsible for processing service-related appeals.

The State will continue to follow these procedures throughout the Demonstration approval period unless modified through an approved Demonstration amendment.

The Bureau administers service and benefit appeals in accordance with the following:

- **Notice Timing.** In accordance with applicable court order and federal regulation, each enrollee receives advance notice of proposed adverse actions affecting his benefits. Generally, enrollees receive 10 days advance notice of a proposed adverse action affecting their benefits. However, in accordance with applicable law, the enrollee may receive fewer than 10 days advance notice if the enrollee’s treating provider proposes the adverse action or if the proposed adverse action involves pharmacy services.
- **Notice Content.** The notice of adverse action contains the following information:
 - (i) the type and amount of services at issue,
 - (ii) a statement of reasons for the proposed action,
 - (iii) the legal basis for the proposed adverse action,
 - (iv) a statement addressing the enrollee’s right to request a fair hearing and an expedited (“emergency”) appeal, and
 - (v) where applicable, a statement addressing the enrollee’s right to continuation of services pending resolution of the appeal pursuant to a hearing decision from the administrative judge.

Additionally, the notice informs an enrollee that he has 30 days to request a fair hearing. In circumstances where an enrollee has a right to request continuation of benefits, the enrollee is instructed how to obtain the continuation of benefits pending the hearing decision.

- **Dispute over individual facts (matters unrelated to public policy).** In order to receive a hearing, the disputed issue must comprise a valid *factual* dispute. A valid factual dispute is a controversy that, if resolved in favor of the enrollee, would prevent the State from taking the action that is the subject of the controversy. For example, the issue under

appeal cannot concern policy decisions such as whether the TennCare program should cover a certain type of medical service. Such a dispute over TennCare coverage policy fails to comprise a valid factual dispute because the question whether to cover the service does not hinge on the enrollee's individual medical situation but instead hinges on broad matters of public health policy.

- The TennCare Solutions Unit (TSU) reviews each request for a hearing to determine if it comprises a valid factual dispute. If the enrollee's appeal fails to raise a valid factual dispute, TSU dismisses the request for a fair hearing. If TSU determines that the enrollee's appeal raises a factual dispute (such as whether a service is "medically necessary"), the case proceeds to a fair hearing.
- When a medical service appeal is scheduled for a hearing, TennCare's Legal Solutions Unit (LSU) provides the enrollee a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing; informs the enrollee of his right to be represented by counsel; cites the legal authority under which the hearing will be held; and provides a brief statement explaining the Bureau's position. An enrollee may represent himself at the hearing; he may choose a friend or family member to represent him; or he may retain legal counsel to represent him. Free or low-cost representation is often available from local Legal Services offices. The Bureau provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

Reference: See TennCare Rules 1200-13-13-.11 & 1200-13-14-.11.

Chapter 6:

Administration



TennCare II Operational Protocol

Section 6.1 Financial Administration

6.1.1 Federal Financial Participation

Federal financial participation (FFP) is the federal government's share of a state's Medicaid program expenditures. In accordance with the TennCare waiver, the Bureau is entitled to FFP at the applicable federal matching rate for the Demonstration as whole—subject to budget neutrality limits as described in Section 6.1.3—as follows:

- Administrative costs, including costs associated with the administration of the Demonstration
- Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with approved Medicaid state plan and waiver authorities,
- Net expenditures and prior period adjustments, authorized through Section 1115(a)(2) of the SSA, with dates of service during the operation of the demonstration, and
- Uncompensated or unreimbursed care expenditures paid through supplemental payment pools, as described in Section 4.3.2.2.

References: STC #55 Extent of Federal Financial Participation for the Demonstration; Section X General Financial Requirements (STCs 50 – 58).

6.1.2 Financial Reporting

In order to receive FFP for TennCare program expenditures, the Bureau is required to meet specific financial reporting requirements, as outlined in the TennCare waiver. These reports, described below, provide a regular accounting of all administrative and service expenditures allowed under the waivers approved for the operation of the TennCare program.

6.1.2.1 Medicaid Program Budget Report -- CMS-37

Responsibility: Financial Operations
Frequency: Quarterly

The CMS-37 is a quarterly financial report submitted by the Bureau that provides a statement of the TennCare program's funding requirements by quarter and estimates matchable Medicaid and TennCare expenditures underlying assumptions for two fiscal years (FYs) – the current FY and the budget FY. CMS makes federal funds available each quarter based on approved estimates. To receive federal financial participation (FFP), the Bureau must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. This information is supplied to CMS electronically.

Reference: STC # 54 (Standard Funding Process)

6.1.2.2 Quarterly Expenditure Report -- CMS-64

Responsibility: Financial Operations
Frequency: Quarterly, within 30 days after the end of each quarter

The CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Title XIX and that reconciles the funding advance made on the basis of the CMS-37 (discussed above) for the same quarter. The Bureau reports on this form all administrative and service expenditures approved for the operation of the TennCare program. When completed, the report shows actual matchable expenditures made in the preceding quarter. CMS reconciles actual expenditures reported in the CMS-64 with federal funding made available for the corresponding period.

Reference: See STC # 50 (Quarterly Expenditure Reports) and # 51 (Reporting Expenditures in the Demonstration).

6.1.2.3 Actual Certified Public Expenditures (CPEs)

Responsibility: Financial Operations
Frequency: Annually, within 12 months of the end of the fiscal year

The Bureau reports actual hospital CPEs to CMS within 12 months after the end of TennCare's fiscal year. Expenditures are based on hospital cost and revenue data that have been reviewed by the Comptroller of the Treasury. The protocol for this process is found in Attachment F of the STCs.

Reference: See STC # 55h (Extent of Federal Financial Participation for the Demonstration) & STC Attachment F (Certified Public Expenditures Protocol).

6.1.2.4 Person-Specific Eligibility and Paid Claims Data

Responsibility: Information Systems
Frequency: Quarterly

The Bureau submits person-specific eligibility and paid claims data electronically to CMS through the Medicaid Statistical Information System (MSIS). The five files, submitted quarterly, include one file containing eligibility and demographic characteristics for each person enrolled in Medicaid at any time during the quarter, and four separate files of claims paid during the quarter for long-term care services, drugs, inpatient hospital stays, and all other types of services.

6.1.2.5 Annual Report on HCBS Waivers--CMS-372 and/or CMS-372(s)

Responsibility: Long Term Services and Supports
Frequency: Annually, within 18 months after the close of the waiver year

The Bureau submits a separate CMS-372/CMS-372(s) for each of its Home and Community Based Services (HCBS) Waiver Programs for individuals with intellectual disabilities: the

Arlington HCBS Waiver; the Statewide HCBS Waiver; and the Self-Determination Waiver. These reports are used by CMS to compare the actual number of services and expenditures incurred under the waivers with the original estimates.

6.1.3 Budget Neutrality

The Bureau is responsible for ensuring that major expenditures remain within the FFP cap. The Bureau's Health Informatics and Fiscal Services Divisions have primary responsibility for monitoring TennCare program's budget neutrality. The process for performing this function has been laid out by CMS.

To assure budget neutrality under the TennCare Demonstration, Tennessee generally uses a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire Demonstration.

Reference: See STC # 59 (Limit on Title XIX Funding).

There are three types of individuals who are eligible for the TennCare program and whose expenditures are funded at Title XIX matching rates: (1) individuals currently eligible for Medicaid under Tennessee's existing Medicaid State Plan; (2) individuals who may be eligible for Medicaid if Tennessee amended its State Plan, or may be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 425.217; and (3) individuals who would not be eligible without Section 1115 authority. Tennessee is at risk for the per capita cost (as determined by the method described below) for current TennCare enrollees in groups 1 and 2 above, but not at risk for the number of Demonstration eligibles in each of the groups. By providing FFP for all current eligibles, Tennessee will not be at risk for changing economic conditions that affect enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the eligibility groups, CMS assures that the Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration. Tennessee will be at risk for both per capita costs and enrollment for Demonstration eligibles that would not be eligible without section 1115 authority (as defined by group 3 above).

Reference: See STCs # 60 (Risk) & # 61 (Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement).

Each yearly ceiling for the TennCare program is the sum of two budget components: (1) the projected cost of services rendered to specified Medicaid Eligibility Groups (MEGs); and (2) the projected Disproportionate Share Hospital (DSH) adjustment. There is a distinct method used for projecting costs for each of these components into the future. Administrative costs under the Demonstration are excluded from the budget neutrality formula except as explained elsewhere.

Reference: See STC # 62a (Budget Neutrality Ceiling).

There are two steps involved in the calculation of the projected cost of services budget limit referenced in (A) above: (1) determining baseline estimates of the number of Medicaid-eligible individuals and the cost per individual; and (2) determining the method for inflating these estimates over time.

The following table presents the projected Per Member-Per Month (PMPM) costs by Demonstration Year (DY), arrived at by using the calculation described in STC # 62(a) (Budget Neutrality Ceiling). The PMPM costs for DY 8 and earlier are calculated pursuant to Attachment B of the November 14, 2006 STCs and paragraph 64(c) of the July 22, 2009 STCs.

Table 6-1: Projected Per Member-Per Month (PMPM) Costs for DYs 12 – 14

Eligibility Group	Trend	DY 12 (SFY 2014)	DY 13 (SFY 2015)	DY 14 (SFY 2016)
EG1 Disabled ¹⁹	5.1%	\$1,561.46	\$1,641.09	\$1,724.79
EG2 Over 65 ²⁰	4.6%	\$1,022.17	\$1,069.19	\$1,118.37
EG3 Children	3.4%	\$468.46	\$484.39	\$500.86
EG4 Adults	4.9%	\$917.79	\$962.76	\$1,009.94
EG5 Duals	4.6%	\$652.99	\$683.02	\$714.44
EG8 Med Exp Child ²¹	3.4%	\$468.46	\$484.39	\$500.86

Source: STC # 62c

Reference: See STC # 62c (Budget Neutrality Ceiling).

The budget neutrality expenditure is the Federal share of the annual PMPM limits for the Demonstration period, plus DSH adjustments for DY 1 through 14, and represents the maximum amount of FFP that the State may receive for Title XIX expenditures during the Demonstration period, as described in STC # 51g. The budget neutrality expenditure limit is equal to (1) the sum of all subcomponents described in STC # 62(a)(i) for all DYs, times the Composite Federal Share described in STC # 62(f), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in STC # 62(d).

Reference: See STC # 62e (Budget Neutrality Ceiling).

The DSH adjustment is based on DSH payments made by Tennessee in 1992 and calculated in accordance with current law. The DSH adjustment for the initial year of the Demonstration (SFY 2003) was \$413,700,907. The DSH adjustment for each subsequent year is based on the DSH allotments established for Tennessee and published in the *Federal Register*. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation that impacts the calculation of DSH allotments.

Reference: See STC # 62d (Budget Neutrality Ceiling).

CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, healthcare-related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda or regulations with respect to the provision of services covered under the Demonstration. CMS reserves the right to make

¹⁹ Includes EG-9 H – Disabled

²⁰ Includes EG-10 H – Over 65

²¹ Optional Targeted Low Income Children funded using Title XIX

adjustments to the budget neutrality cap if any healthcare-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and healthcare-related tax provisions of § 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

Reference: See STC # 63 (Future Adjustments to the Budget Neutrality Expenditure Limit).

CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

Table 6-2: Cumulative Target Limit

DY	Cumulative Target Definition	Percentage
Years 1 through 6	Cumulative budget neutrality cap plus:	0.5 percent
Years 1 through 7	Cumulative budget neutrality cap plus:	0.25 percent
Years 1 through 14	Cumulative budget neutrality cap plus:	0 percent

Reference: See STC # 64 (Enforcement of Budget Neutrality).

Section 6.2

TennCare Information System Administration

This chapter provides a description of the TennCare Management Information System (TCMIS), the primary information system used by the Bureau for the collection, processing, and storage of data necessary for administering the multiple programs and benefits within TennCare. It also includes a discussion of the system's design, how it interfaces with outside agencies and providers, and how it supports the Bureau's compliance with HIPAA and HITECH regulations.

6.2.1 TennCare Management Information System (TCMIS)

TCMIS is maintained and operated by an outside contractor, performing as the Facilities Manager. TCMIS has the flexibility to support project management as well as TennCare Demonstration and reform modifications, such as multiple benefit plans and carve-out programs. TCMIS also automates many existing processes, such as imaging of letters generated to recipients and providers.

The following sections identify and describe the functions of the major sub-systems of TCMIS.

6.2.1.1 Eligibility and enrollment

TCMIS houses the master eligibility file for the TennCare program. This sub-system maintains and accepts updates to current and historical day-specific eligibility demographic information for the TennCare Medicaid and TennCare Standard populations, including Medicare beneficiaries. Updates to the TennCare program master eligibility file are currently received from multiple sources:

- Department of Human Services (DHS)
- Department of Health (DOH)
- Department of Children's Services (DCS)
- Department of Intellectual and Developmental Disabilities (DIDD)
- Federally Facilitated Marketplace (FFM)
- Social Security Administration (SSA)

The eligibility sub-system is a centralized core component of the TCMIS used for all functions that require eligibility and enrollment data (e.g., claims processing, enrollment processing, and capitation payments). The system's maintenance function is to accept and maintain accurate, current and historical source data on eligibility information.

The major eligibility and enrollment functions of TCMIS are to:

- Establish and maintain a single client identifier for each person that can be associated with historical identifiers and other family members.
- Track all categories of eligibility, including begin and end dates.

- Manage acceptance of Medicare, TennCare Medicaid and TennCare Standard eligibility records and updates from internal and external agencies.
- Process eligibility and maintenance updates from DHS, DOH, DCS, DIDD, FFM and SSA, maintaining historical eligibility data from each.
- Use eligibility information for notice generation for redetermining eligibility for the TennCare Standard population annually or upon a qualifying event, if needed.
- Process MCO/PBM/DBM enrollment/disenrollment.
- Assign enrollees to a Managed Care Contractor (MCC) and generate MCO/PBM/DBM enrollment rosters.
- Assure that demographic information is maintained and identifiable by data source.
- Identify persons with special needs or in special populations.
- Collect and distribute third party liability information.

The eligibility and enrollment sub-system accepts the following eligibility data:

- TennCare Medicaid and TennCare Standard eligibility data from the DHS ACCENT system.
- Presumptive eligibility for pregnant women from DOH.
- Patient liability information from DHS.
- SSI eligibility data from SSA.
- DCS-immediate eligibility data through the DHS ACCENT system.
- Breast and Cervical Cancer Treatment eligibility data from DHS.
- Data from the MCCs regarding priority enrollees who have been identified by TennCare as vulnerable due to certain mental health diagnoses.
- Buy-In eligibility data from CMS.

This sub-system interfaces with the MCOs, Pharmacy Claims Processor, and Dental Benefits Manager to obtain enrollee information regarding third-party resources, Medicare benefits and buy-in eligibility. The sub-system also interfaces with the Beneficiary Data Exchange (BENDEX), Medicare Electronic Data Base (EDB), and the Medicare Modernization Act (MMA) Part D file on dual eligibles. The External Quality Review Organization (EQRO) also interfaces with this subsystem in the performance of its activities.

6.2.1.2 Encounter data processing

The encounter data sub-system collects, validates, and processes encounter data submitted by Managed Care Organizations and the State's Pharmacy and Dental Benefit Managers. These contractors must transfer applicable encounter data files to TCMIS using ASC X12N and NCPDP formats.

TCMIS validates the accuracy of CPT codes, HCPCS codes, Revenue Codes, ICD-9-CM codes and ADA-CDT codes. All encounter data also go through several edit processes, including all seven levels of HIPAA compliance testing and additional edits for content and duplication.

6.2.1.3 Claims processing

TCMIS has the capacity to receive, track, and process paper or electronic claims. TCMIS adjudicates claims from: Nursing Facilities for Level 1 and Level 2 claims, DIDD for Intellectual Disabilities (ID) provider payments, Home and Community Based Services (HCBS) Waiver Providers, DCS, Commission on Aging, ICF/IID claims, and the Coordination of Benefits Agreement (COBA) Program for Medicare professional crossovers and Medicare institutional cross-over claims. The system receives and translates electronic claims in accepted HIPAA transaction formats.

6.2.1.4 Provider enrollment

The provider enrollment sub-system maintains provider numbers for Medicare crossover providers, out-of-state providers and TennCare-only providers. All providers contracting with a TennCare MCC will be assigned a TennCare provider number, regardless of whether the MCC tracks or identifies the provider by an alternate number. The sub-system also tracks national provider identification numbers as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The sub-system aggregates information from provider application and enrollment forms, provider network files submitted by MCCs, initial enrollment from the Medicare Intermediary and Carrier data, the Medicare Provider Sanction List from CMS, the CMS Clinical Laboratory Improvement Act database, DCS, DMH, DIDD, and DOH provider data. The provider enrollment file is used to monitor provider networks, generate provider mailings, track and report provider enrollment statistics, and to process claims and encounter information.

6.2.1.5 Third Party Liability

The Third Party Liability (TPL) subsystem ensures that TennCare is the payer of last resort for services provided to enrollees. TPL information is maintained in TCMIS to provide the capability to manage cost avoidance and cost recoveries of claims processing.

6.2.2 Production and Ad Hoc Reporting

The TennCare production and ad hoc reporting systems support a variety of activities. TCMIS reporting capabilities are used to produce routine management reports, operational reports and required federal and state reports; to monitor MCC performance; and to support financial and clinical studies.

6.2.2.1 Federal reporting requirements

The federal reports listed below are produced from data stored in TCMIS and affiliated systems. A description of some of these reports can be found in Section 6.1.2.

- Medicaid Program Budget Report – CMS-37
- Quarterly Expense Report – CMS-64
- Annual Report on Home and Community-Based Services Waivers – CMS-372 and CMS-372(s)
- EPSDT Report – CMS-416
- Quarterly Person-Specific Eligibility and Paid Claims Data – CMS-2082 (MSIS)

6.2.2.2 MCC monitoring

TCMIS assists several Bureau divisions in completing their MCC monitoring activities, including:

- Monitoring MCC program administration
- Monitoring enrollment growth, expenditures and cost trends
- Monitoring provider network adequacy
- Monitoring quality and access to care
- Monitoring contract compliance

Additionally, the Tennessee Department of Commerce and Insurance (TDCI) monitors the financial solvency of the MCCs, analyzes their annual financial statements, and performs onsite audits of their claims processing for accuracy and timeliness of processing.

6.2.2.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking system

The EPSDT program provides health screenings and treatment services to TennCare enrollees under the age of 21 to promote early detection of potentially chronic and disabling health conditions. The responsibility for providing EPSDT services to TennCare enrollees has been contracted to the MCOs, with the Quality Oversight Unit performing monitoring activities to ensure compliance with federal EPSDT requirements.

TCMIS includes a component to support the collection and maintenance of information related to EPSDT and immunization services. The system includes a mechanism to track whether persons are missing services and to generate reminder notices about upcoming and overdue appointments. This centralized system provides TennCare with the ability to track EPSDT and immunization status as members transfer from one MCO to another.

6.2.3 HIPAA and HITECH Compliance

In addition to Medicaid confidentiality regulations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enhanced in 2010 by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires state public health benefit programs, like TennCare, to ensure the privacy and security of protected health information (PHI). The Bureau takes the privacy and security of individually identifying data of its enrollees very seriously. TennCare's Privacy and Public Records Office, in collaboration with the Information Security Office, oversees activities related to the implementation and maintenance of, and adherence to, privacy and security policies that address the permitted use and disclosure of PHI and Federal Tax Information, as well as the appropriate administrative, physical, and technical safeguards necessary to secure the information. TCMIS provides configurable logging for audit purposes and supports granular definitions of access to ensure the appropriate use of data.

HIPAA and HITECH also require that the Bureau adhere to administrative data standards for electronic transmissions. TCMIS supports current HIPAA standards and code sets for required transactions. The system also employs a flexible translator module in order to accommodate future transaction standards. TennCare's HIPAA Electronic Data Interchange (EDI) Office is responsible for implementing version upgrades of transaction formats, such as the HIPAA X12 version 5010 and NCPDP version D.0, and new sets of standards that regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances.

Section 6.3

Managed Care Contractor Encounter Data

Each of the Managed Care Contractors (MCCs)—MCOs, TennCare Select, the Pharmacy Benefits Manager (PBM), and the Dental Benefits Manager (DBM)—is required to submit individual encounter records on a regular basis for services provided to TennCare enrollees. This chapter describes encounter data reporting requirements for the MCCs, including the types of data, the report format and frequency, and the functional capabilities of the reporting information system. Encounter data is required in order to monitor quality of care and service utilization and cost trends; support rate-setting; and satisfy federal reporting requirements.

6.3.1 Information Systems Requirements

To ensure the timely submission of accurate encounter data, all MCCs are required to maintain and operate information systems capable of capturing individual units of service and interfacing with the TennCare Management Information System (TCMIS). Prior to beginning operations, all vendors must successfully complete a readiness review of their information systems to ensure that their processing system satisfies the functional and informational requirements of the TennCare program. Each vendor has an access network established with the Bureau for sharing data. Any software or additional communications network required for access is provided by the MCCs. To ensure the timely capture and reporting of data, MCCs must process 99.5 percent (99.5%) of claims within 60 days of receipt. The Bureau's interface standard for data transfers is via a secure FTP, using HIPAA transaction formats.

6.3.2 Reporting Frequency

All MCCs (MCOs, DBM, and PBM) participating in the TennCare program are required to submit individual encounter data generated in the process of their regular financial cycle, typically on a weekly basis. Individual encounter records for hospital, home health, professional, community health clinic services, ambulance services, dental services, pharmacy services, hospice services, long-term services and supports, and other medical services are required.

6.3.3 Reporting Format

To support the uniform reporting of encounter data, all MCCs are required to use standardized claim formats. The required formats are:

Type of Claim	Required Format
Professional	ASC X12N 837P
Institutional	ASC X12N 837I
Dental	ASC X12N 837D
Pharmacy	NCPDP batch

Once claims for payment are processed, MCCs must submit encounters for individual units of service to the Bureau. Generally, MCC encounter files are generated as part of the standard

financial cycle and submitted to the Bureau, most often being received and processed concurrent with or shortly following issuance of a check from the MCC. For the MCOs, required minimum data elements for encounter reporting are included in the Contractor Risk Agreement. The critical data elements for the pharmacy and dental programs are included in the contracts with the Pharmacy and Dental Benefits Managers.

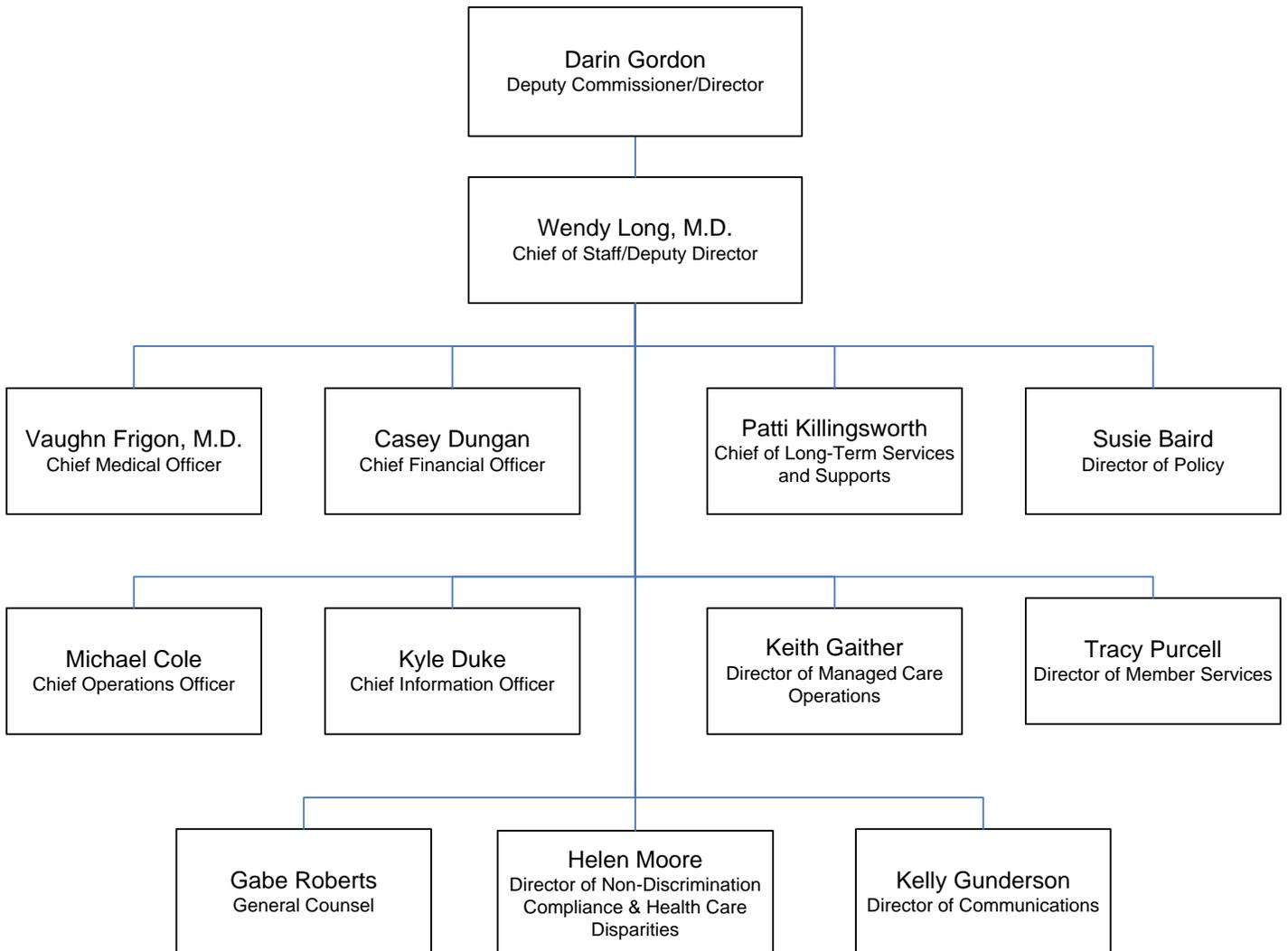
6.3.4 Data Integrity

Upon receipt of encounter data files, the Bureau conducts several validation edits ranging from verifying that financial fields have numeric characters to verifying that required fields, such as individual identifiers (e.g., Patient Last Name, ID Number), are populated. Any error that produces a HIPAA compliance edit results in the rejection of the individual encounter on the Edifecs front end. The Bureau validates all seven levels of SNIP edits for determining and reporting HIPAA compliance during validation processing²². In the event that edits identified as threshold edits are greater than two percent (2%), the entire file is rejected in the TCMIS. The MCC is usually given two business days to submit a replacement file. In the unlikely event that an MCC does not comply with encounter data reporting requirements, the Bureau may apply liquidated damages or other intermediate sanctions as specified in the Contractor Risk Agreement.

²² All "HIPAA" edits are defined by a workgroup of WEDI (Workgroup for Electronic Data Interchange) called SNIP (Strategic National Implementation Process), which developed a standard for edit classifications. The 7 developed levels are called SNIP levels 1 to 7.

Attachment A

Bureau of TennCare Organizational Chart



Attachment B

Definitions of “Insurance” under TennCare

Types of Policies that Count as "Insurance"	Types of Policies that Do Not Count as "Insurance"
Any hospital and/or medical expense-incurred policy	Short-term coverage
Medicare	Accident coverage
TRICARE	Fixed indemnity insurance
COBRA	Long-term care insurance
Medicaid	Disability income contracts
State health risk pool (AccessTN) ²³	Limited benefits policies, meaning a policy of health coverage for a specific disease (such as cancer), or an accident occurring while engaged in a specified activity (such as school-based sports), or a policy that provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (for example, hospital indemnity)
Nonprofit health care service plan contract	Credit insurance
Health maintenance organization subscriber contract	School-sponsored sports-related injury coverage
Pre-Existing Condition Insurance Plan (PCIP) ²⁴	Coverage issued as a supplement to liability insurance
An employee welfare benefit plan to the extent that the plan provides medical care to an employee or his dependents (as defined under the terms of the plan) directly through insurance, any form of self-insurance, or a reimbursement mechanism	Automobile medical payment insurance
Coverage available to an individual through membership in a professional organization or a school	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
Coverage under a policy covering one person or all the members of a family under a single policy	

²³ AccessTN stopped accepting new applications on October 15, 2010. Enrollment reopened on December 2, 2010, but premium assistance remains closed at this time.

²⁴ PCIP was created as part of the Affordable Care Act (ACA) of 2010. The PCIP program provides a new health coverage option for persons who have been uninsured for at least six months, have pre-existing conditions or have been denied health coverage because of their health conditions, and are a U.S. citizens or legal residents. PCIP is a transitional program in effect until January 1, 2014, when the American Health Benefit Exchanges are scheduled to begin operation in every state.

Types of Policies that Count as "Insurance"	Types of Policies that Do Not Count as "Insurance"
<p>where the contract exists solely between the individual and the insurance company</p> <p>Any of the above types of policies where:</p> <ul style="list-style-type: none"> The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted, The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached. 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. <p>Any of the types of policies listed above will be considered health insurance even if one or more of the following circumstances exists:</p> <ul style="list-style-type: none"> The policy contains fewer benefits than TennCare; The policy costs more than TennCare; or The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so. 	<p>A medical care program of the Indian Health Services (IHS) or a tribal organization</p> <p>Benefits received through the Veteran's Administration</p> <p>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.</p>

Attachment C

Qualifying Medical Conditions Used to Determine Medical Eligibility

- Alpha-1-Antitrypsin Deficiency 277.6
 - ALS 335.20
 - Alzheimer's 331.0
 - Arrhythmias 426-426.9, 427-427.9
 - Arthrogryposis 728.3
 - Asbestosis 501
 - Ataxia Telangiectasia 334.8
 - Autism 299.0, 299.1, 299.8, 299.9
 - Cancer, with active treatment in past 12 months (includes Hodgkin's Disease, leukemia, lymphoblastoma, lymphoma, malignant tumor, melanoma, and sarcoma) 140-149,150-159,160-165, 170-172, 174-176, 179-189, 190-197, 198-199, 200-208
 - Cardiac Pacemakers V45.0, V45.00-V45.09
 - Cardiomyopathy 425, 425.0-425.9
 - Cerebral Palsy 343, 343.0-343.9
 - Cerebrovascular Accidents (Thrombosis/ Hemorrhage) 430, 431, 432, 432.0-432.9, 433.0-433.9, 434, 434.1-434.9, 436
 - Chronic Obstructive Pulmonary Disease (COPD) 491.2-491.9, 492.0, 492.8, 496
 - Chronic Pancreatitis 577.1
 - Cirrhosis of the Liver 571.5, 571.6
 - Coagulation Defects (Hemophilias, Christmas Disease, and other clotting factor disorders) 286.0-286.9
 - Congenital Adrenal Hyperplasia 255.2
 - Congenital Heart Disease 745.0-745.9, 746.0-746.9, 747.0-747.49
 - Congenital Hypothyroidism 243
 - Congestive Heart Failure 428.0-428.9
 - Coronary Artery Disease (Myocardial Infarctions, Open Heart Surgery) 410.0-410.9, 411.0-411.89, 412, 413.0-413.9, 414.0-414.9
 - Crohn's Disease 555.0-555.9
 - Cystic Fibrosis 277.0, 277.01
 - Demyelinating Diseases 340, 341.0-341.9
 - Diabetes, Type 1, with comorbidity; Juvenile Diabetes 250.1-250.9
 - Down Syndrome 758.0
 - Epilepsy 345.0-345.9
 - Esophageal varices 456.0, 456.1,456.2
 - Fetal Alcohol Syndrome 760.71
 - Fragile X-Syndrome 759.83
 - Friedreich's Ataxia 334.0
 - Galactosemia 271.1
 - Hamman-Rich Disease 516.3
 - Heart Valve Replacement V42.2
 - Hepatitis C 070.41, 070.44, 070.51, 070.54
 - HIV/AIDS 042, 079.53, 136.3, 176.0-176.9
 - Huntington's Chorea 333.4
 - Hydrocephalus 742.3
 - Kidney Failure, with dialysis 584.5-584.9, 585, 586
 - Lead Poisoning 961.2, 984.0-984.9
 - Leukodystrophies 330.0
 - Lipidosis 272.7
 - Maple Syrup Urine Disease 270.3
 - Marfan's Syndrome 759.82
 - Mucopolysaccharidosis 277.5 (types 1-6)
 - Multiple Sclerosis 340
 - Muscular Dystrophies 359.0, 359.1,359.2, 359.3
 - Myasthenia Gravis 358.0
 - Neurofibromatosis 237.70, 237.71,237.72
 - Prader-Willi Syndrome 759.81
 - Prune Belly Syndrome 756.71
 - Spina Bifida 741.0-741.9
 - Osteogenesis Imperfecta 756.51
 - Parkinson's Disease 332.0, 333.0
 - Phenylketonuria (PKU) 270.1
 - Polyarteritis Nodosa 446.0
 - Polycystic Renal Disease 753.12-753.14
 - Quadriplegia 344.00-344.09
 - Rheumatic Heart Disease 391.0-391.9, 392.0-392.9, 393, 394.0, 394.1, 395.0-395.9, 396.0-396.9, 397.0-397.9, 398.0-398.99
 - Rheumatoid Arthritis 714.0-714.89
 - Scleroderma 710.1
 - Sickle Cell Disease 282.60-286.69
 - Still's Disease 714.30
 - Syringomyelia 336.0
 - Systemic Lupus Erythematosus 710.0
 - Thalassemia Major 282.4
 - Traumatic Brain Injury 850.4, 851.0-851.9
 - Tuberculosis 011.0-011.9, 012.0-012.8, 013.0-013.9, 014.0-014.8, 015.0-015.9,016.0-016.9
 - Ulcerative Colitis 556.0-556.9
 - Wilson's Disease 275.1
- Organ Transplant 017.0-017.9, 018.0-018.9
- Bone Marrow V42.81
 - Cornea V42.5
 - Heart V42.1
 - Heart Valve V42.2, V43.3
 - Intestines V42.84
 - Kidney V42.0
 - Liver V42.7
 - Lung V42.6
 - Pancreas V42.83
- Surgery
- Open Heart Surgery (CPT Codes) 33517-33530, 33533-33545, 33572, 33510-33516
- Mental Health
- Anxiety, Dissociative and Somatoform Disorders 300.00-300.02, 300.09, 300.15, 300.21, 300.23, 300.3, 300.4, 300.9, 300.11, 300.81, 300.22
 - Bipolar Disorders 296.1, 296.3, 296.4, 296.5, 296.6, 296.7, 296.8-296.89
 - Dementias 290.40, 290.41, 290.43
 - Depressive Disorder (NEC) 311
 - Disturbance of Conduct (NEC) 312.30, 312.34, 312.81, 312.82, 312.89, 312.9, 313.81, 313.89
 - Drug Induced Mental Disorders 292.0, 292.11, 292.12, 292.89, 292.9
 - Eating Disorders 307.1, 307.50, 307.51
 - Episodic Mood Disorders 296-296.9, 296.00- 296.06, 296.10-296.16, 296.20-296.26, 296.30-296.36, 296.40-296.46, 296.50-296.56, 296.60-296.66, 296.70, 296.80-296.82, 296.89, 296.90, 296.99

- Hyperkinetic Syndrome of Childhood 341.00, 314.01, 314.9
- Other Non-organic Psychoses 298.1, 298.9
- Personality Disorders 301-301.13, 301.20-301.22, 301.50, 301.51, 301.59, 301.60, 301.81-301.84, 301.89
- Pervasive Development Disorders 299.00, 299.80, 299.90
- Personality Change due to Brain Damage 310.1
- Psychotic Disorders (including Delusional Disorders) 296.0-296.9, 297.0-297.9, 298.0-298.9, 299.0-299.9
- Schizophrenic Disorders 295.0-295.9, 295.00-295.05, 295.10-295.15, 295.20-295.25, 295.30-295.35, 295.40-295.45, 295.50-295.55, 295.60-295.65, 295.70-295.75, 295.80-295.85, 295.90-295.95
- Transient Mental Disorders 293.0, 293.81, 293.83, 294.8

Attachment D

List of Current TennCare Managed Care Contractors (MCCs)

Managed Care Organizations (MCOs)

UnitedHealthcare Community Plan

8 Cadillac Drive, Suite 100
Brentwood, Tennessee 37027
1-800-690-1606

AMERIGROUP Three Lakeview Place

22 Century Blvd., Suite 310
Nashville, TN 37214
1-800-600-4441

BlueCare and Volunteer State Health Plan

1 Cameron Hill Circle
Chattanooga, TN 37402
TennCare Select 1-800-263-5479
BlueCare 1-800-468-9698

Dental Benefits Manager (DBM)

DentaQuest
465 Medford St.
Boston, MA 02129
1-855-418-1622 (Member Information Line)
1-855-418-1623 (Provider Information Line)

Pharmacy Benefits Manager (PBM)

Magellan Pharmacy Solutions

11013 W Broad Street
Suite 500
Glen Allen, VA 23060
1-800-884-2822

Attachment E Hardship Criteria for MCO Changes

The following six criteria must be met to direct a hardship MCO change. If these criteria are not met, and the enrollee has ongoing concerns about his PCP or specialty care, TennCare will work with his current plan, resolve the concerns, and ensure appropriate care is provided. Deficiencies in MCO networks will be communicated to contract compliance and quality oversight units for review and assessment of appropriate sanctions or damages. An enrollee for whom an MCO change is denied will be given an opportunity to file an appeal if he desires to do so.

Hardship Criteria (all 6 criteria must be met):

1. An enrollee has a medical condition that requires complex, extensive and ongoing care.
2. The enrollee's PCP and/or specialist has stopped participating in the enrollee's current MCO network and has refused continuation of care to the enrollee in his current MCO assignment.
3. The ongoing medical condition of the enrollee is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care.
4. The current MCO has been unable to negotiate continued care for this enrollee with current PCP and/or specialist.
5. The current provider of services is in the network of one or more alternate MCOs.
6. An alternate MCO is available to enrollees (i.e. has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the enrollee's region).

Reference: See TennCare Medicaid rule 1200-13-13-.03 & TennCare Standard rule 1200-13-14-.03.

Hardship MCO change will NOT be granted in the following situations:

- The enrollee is unhappy with current plan or PCP, but no hardship medical situation exists.
- The enrollee claims lack of access to services but the plan meets the State's access standards.
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by MCO.
- The enrollee is concerned that a current provider might drop out of the plan in the future.

- Medicare/Medicaid recipients who (with the exception of pharmacy) may use their choice of providers, regardless of network affiliation.
- The enrollee's PCP is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

Hardship MCO changes will be directed or referred to the Administrative Solutions Call Center to process.

Reference: See TennCare Medicaid rule 1200-13-13-.03; TennCare Standard rule 1200-13-14-.03; & STC # 39 (Plan Enrollment and Disenrollment).

CHOICES and MCO Changes

In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

Reference: See TennCare Medicaid rule 1200-13-13-.03 & TennCare Standard rule 1200-13-14-.03; STC # 39(Plan Enrollment and Disenrollment).

Attachment F Helpful Telephone Numbers

Tennessee Health Connection

1-855-259-0701

TennCare TTY Information Line for persons with speech & hearing impairments

1-866-771-7043

TennCare Advocacy Program (English and Spanish)

1-800-758-1638

Statewide Mental Health Crisis Line

1-855-CRISIS-1 or 1-855-274-7471

TennCare Solutions Unit (TSU)

1-800-878-3192

Bureau of TennCare Office

1-800-342-3145

TennCare Fraud and Abuse Line

1-800-433-3982

FAX (615) 256-3852

E-mail address: TennCare.Fraud@tn.gov

Attachment G

Terms and Conditions for Access

Non-Specialty Care Network Standards

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

Primary Care Physician or Extender:

- Distance/Time Rural: 30 miles
- Distance/Time Urban: 20 miles
- Patient Load: 2,500 or less for physician; one-half this for a physician extender.
- Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from the date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Documentation/Tracking requirements:
 - Documentation -- Plans must have a system in place to document appointment scheduling times.
 - Tracking -- Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

Specialty Care and Emergency Care:

Referral appointment to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts. Waiting times shall not exceed 45 minutes.

Hospitals:

Transport time will be the usual and customary, not to exceed 30 miles, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Long-Term Services and Supports:

Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for TennCare enrollees in suburban areas, and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.

General Optometry Services:

Transport time will be the usual and customary, not to exceed 30 miles, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary not to exceed three weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Other:

All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary": access that is equal to or greater than the currently existing practice in the fee-for-service system.

Reference: MCO Contractor Risk Agreement Attachment III General Access Standards

Specialty Care Network Standards

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

1. The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

2. The following access standards are met:

- Travel distance does not exceed 60 miles for at least 75% of non-dual members and
- Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Division was compared to the size of the population in each Grand Division. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Division to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty
Specialty Number of Non-Dual Members

Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child and adolescent)	150,000
Urology	30,000

Reference: MCO Contractor Risk Agreement Attachment IV Specialty Network Standards

Behavioral Health Services

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirements	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Service	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24-Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region for ADULT members. <hr/> Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (may include Day Treatment [adult], Intensive Day Treatment [Children & Adolescent] or Partial Hospitalization)	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel Distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification – within 4 hours in an emergency and 24 hours for non-emergency

Service Type	Geographic Access Requirements	Maximum Time for Admission/Appointment
24-Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region for ADULT members The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region for CHILD members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations & 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR’s network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR’s response demonstrates the existence of alternate measures or unique conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

Reference: MCO Contractor Risk Agreement Attachment V Access & Availability for Behavioral Health Services

Attachment H TennCare II Waiver Special Terms and Conditions (STCs)

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Source: Demonstration Approval Period: July 1, 2013 – June 30, 2016

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