



# TENNCARE OPERATIONAL PROTOCOL



**Incorporating the July 1, 2010  
Demonstration Extension**

**Bureau of TennCare  
Nashville, Tennessee**

**Revised October 2011**

## Disclaimer

The purpose of the TennCare 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 discussion of the Demonstration and a referral to other documents that provide more information about the TennCare program.

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## Abbreviations & Acronyms Used in TennCare

A & D	Alcohol and Drug
AAAD	Area Agency on Aging and Disability (sometimes referred to as a “Triple A”)
ACA	Affordable Care Act of 2010 (This is 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 (in the U.S. DHHS)
ALA	Administrative Lead Agency
ALJ	Administrative Law Judge
AMA	American Medical Association
APN	Advanced Practice Nurse
APSP	Adjusted Periodic Screening Percentage
AQS	Annual Quality Survey
ASH	Abortion, Sterilization, and Hysterectomy
ASO	Administrative Services Only
BBA	Balanced Budget Act
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
CMHA	Community Mental Health Agency (case management)
CMHC	Case Management Health Center
CMS	Centers for Medicare and Medicaid Services
CMSO	Center for Medicaid and State Operations (under CMS)
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
CRG	Clinically Related Group
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) <sup>1</sup>
DM	Disease Management
DMH	<i>See TDMH</i>
DOB	Date of Birth
DOH	[Tennessee] Department of Health
DSH	Disproportionate Share Hospital
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, 4 <sup>th</sup> Edition, Text Revision
DSP	Dental Screening Percentage
DUR	Drug Utilization Review
DY	Demonstration Year (July 1 – June 30)
EAH	Essential Access Hospital
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
FEA	Fiscal Employer Agent
FERP	Federal Estate Recovery Program
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
GOCCC	Governor's Office of Children's Care Coordination
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration (predecessor to CMS)
HCPCS	Healthcare Common Procedure Coding System

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<sup>1</sup> 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>.

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 <sup>th</sup> Revision
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
IEP	Individual Education Plan
IHS	Indian Health Service
IMD	Institution for Mental Diseases
IME	Indirect Medical Education
IP	Inpatient
IRS	Internal Revenue Service OR Identical, Related, or Similar (Drugs)
IS	Information Systems
JCAHO	Joint Commission for Accreditation of Hospital Organization (a/k/a the Joint Commission)
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
LTC	Long-term Care
LTE	Less Than Effective (Drugs)
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	Memo of Understanding
MR	Mental Retardation
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 Reports
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
PLHSO	Prepaid Limited Health Service Organization
PMPM	Per Member Per Month
PNA	Personal Needs Allowance
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act of 2010
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSA	Public Service Announcement
QDWI	[Medicare] Qualified Disabled and Working Individuals
QIT	Qualifying Income Trust (as in Miller Trust)
QMB	Qualified Medicare Beneficiary
QMRP	Qualified Mental Retardation Professional
QO	Quality Oversight
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 (as defined by Medicare)
SNP	Special Needs Plan
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 or Traumatic Brain Injury
TCM	TennCare Medicaid or Targeted Case Management
TCMIS	TennCare Management Information System
TCS	TennCare Standard
TDCI	[Tennessee] Department of Commerce and Insurance
TDMH	[Tennessee] Department of Mental Health <sup>2</sup>
TDOH	[Tennessee] Department of Health
TENNderCare	TennCare for Kids – EPSDT
TNCSA	Tennessee Community Services Agency
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

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<sup>2</sup> Effective January 15, 2011, with the transfer of Developmental Disabilities services to DIDD, TDMHDD changed its name to the Tennessee Department of Mental Health.

## List of “User Friendly” Definitions

**Note: For legal purposes, the definitions in the State rules and the State’s contracts are to be used. The following list is intended to provide “user friendly” program definitions for general reference only.**

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
CRA	TennCare/MCO Contractor Risk Agreement (CRA) (Middle, East & West)

**Activities of Daily Living (ADLs).** ADLs are self-care activities in which most people take part 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 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.

**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 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 care services under the TennCare program. (See Single Point of Entry.)

**Assisted Care Living Facility (ACLF).** Community-based residential alternative to nursing facility care that provides and/or arranges for daily meals, personal, 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 shall 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 situations and for various reasons by TennCare.

“At risk” Managed Care Organization (MCO) – When an MCO is “at risk”, it is responsible for payment of covered services. The State pays the MCO a monthly fee for each enrollee assigned to its plan. TennCare has no financial responsibility beyond the fee paid for each enrollee. (See Capitation Payment.)

Adults "at risk of abuse and neglect" (e.g., CHOICES enrollees) – Adults who lack coping skills and whose living environments place them in danger of being abused by others or neglected by those who have assumed the responsibility of caring for them.

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.<sup>3</sup>

Persons "at risk of institutionalization" – People who, without the availability of certain supports and services, will likely require placement in an institutional setting such as a Nursing Facility.

**Attendant Care.** Under the CHOICES program, hands-on assistance, safety monitoring, and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits. This care may include:

- Assistance with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and walking;
- Assistance with instrumental activities of daily living (IADLs) that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as—
  - Picking up medications or shopping for groceries,
  - Meal preparation or household tasks such as making the bed or washing soiled linens and bedclothes, or
  - Continuous monitoring and supervision during the period of service delivery.

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<sup>3</sup> Tennessee Code Annotated (T.C.A.) Section 37-3-602(2) (<http://www.lexisnexis.com/hottopics/tncode/>)

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.** As a part of the plan of care for all CHOICES members receiving HCBS, it is a written plan specifying how a member's needs will be met in the event that a provider's back-up plan fails or a service is not delivered as scheduled. It 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 or without regard to the amount of services used during the payment period.

**Caretaker Relative.** A relative who is taking care of a Medicaid-eligible child. Caretaker relatives may be eligible for TennCare in the Standard Spend Down (SSD) category if they meet the category's criteria and the category is open for enrollment.

**Case.** A household that includes some members who are TennCare-eligible.

**Children's Health Insurance Program (CHIP).** 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 below 200% of poverty are considered "CHIP children" in the TennCare II extension. Funding for services for "CHIP children" comes from Title XXI rather than Title XIX. Formerly known as SCHIP.

**CHOICES (TennCare CHOICES in Long-term Care).** A program that provides long-term care 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 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 Group 1.** An individual of any age who is receiving Medicaid-reimbursed long-term care 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), who qualify either as SSI recipients or as members of the 217-Like Demonstration population, and who need and are receiving HCBS as an alternative to NF care.

**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 to eligible members, that offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is 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. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving 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 Home and Community Based Services.** Under the CHOICES program, the opportunity for a member assessed to need specified types of HCBS, including attendant care, personal care visits, homemaker services, in-home respite care or companion care, to elect 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).

**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 the 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 CMS and may be provided at the MCC'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 MCC's judgment, are cost-effective; or
- Preventive in nature and offered to avoid the development of conditions that, in the MCC'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 MCC'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, shall 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 enrollees through their managed care contractors. Additional services are available through the TennCare CHOICES program, as described in the Bureau's rules at 1200-13-01-.05. CHOICES services are available only to persons who qualify for and are enrolled in the CHOICES program.

**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. TennCare is a Demonstration Project designed to show that a managed care approach can be used to extend coverage to people who would not otherwise be eligible for Medicaid, without costing the state more money than the state would have spent on a Medicaid program only, and without compromising service quality.

**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 by TennCare. 42 CFR § 438.56 uses the term "disenrollment" to refer to the process by which individuals change MCOs. TennCare has historically used the term "disenrollment" to refer to the process by which a person who has lost eligibility for TennCare is removed from the program. STC Section XIII, Part 1 uses the term "disenrollment" in this manner. 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. The proper interpretation of the term "disenrollment" depends upon the context in which it is used.

**Dual Eligible.** A person who is eligible for both Medicare and TennCare, meaning he is eligible in a TennCare category that permits access to insurance AND he has Medicare.

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 TennCare. 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 TennCare and who has been enrolled in the program.

**Family.** In the context of eligibility for benefits, parents and related children who live together in the same household. "Related" individuals include parents' spouses who live in the home, as well as siblings, half-siblings, and step-siblings. Caretakers (such as grandparents) who are not parents but who are present in the home are not included in the definition of "family" unless they request to be included. Children living at home are removed from the "family" once they turn 21 (for TennCare Medicaid) or they marry, whichever comes first. Children turning 19 and enrolled in TennCare Standard are reverified separately for eligibility in Medicaid categories.

**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 care services 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/MR) 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.

**Fiscal Employer Agent (FEA).** An entity contracting with the State and/or an MCO that helps CHOICES members participating in consumer direction of HCBS. The FEA 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 some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**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) authorized by the Tennessee Department of Finance and Administration to pay for and/or coordinate medical, behavioral, and long-term care services 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 not covered by Tennessee's Title XIX (Medicaid) State Plan that are provided as an alternative to long-term care institutional services in a Nursing Facility (NF) or an Intermediate Care Facility for persons with mental retardation (ICF/MR). Under CHOICES, HCBS is available to members qualifying for and enrolled in CHOICES. HCBS does not include home health or private duty nursing services.

**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 shall be 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) and only 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.

**Immediate Eligibility.** A process by which children entering state custody (other than those going into Youth Development Centers [YDCs]) are assigned to TennCare Select so that they can start receiving TennCare-reimbursed health care services immediately. If the result of the eligibility determination process is that the child is not eligible for TennCare, DCS will refund to TennCare Select any payments made on the child's behalf.

Under CHOICES, the Bureau can make a preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group. This determination allows enrollment in CHOICES Group 2 and immediate access to a limited package of HCBS, while waiting for a final determination of eligibility. The qualifications for Immediate Eligibility in CHOICES are found in TennCare rule 1200-13-01-.02. Immediate Eligibility shall only be for specified HCBS (no other covered services) and for a maximum of 45 days for individuals who are not already enrolled in TennCare.

**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.

**In-home Respite Care.** Services provided under the CHOICES program to individuals unable to care for themselves, furnished on a short-term basis in the individual'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 a 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 ability to drive or use public transportation.

**Managed Care Contractor (MCC).** A managed care organization 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 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.** 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 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) or the Tennessee Department of Human Services (DHS). 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.

**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 will 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 below 200% of poverty OR be determined “Medically Eligible” at any income level. 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.** This term is defined in *T.C.A. 71-5-144* as a medical item or service that meets the criteria in that statute, and applies to TennCare enrollees. An enrollee is not entitled to receive and TennCare shall not be required to pay for any items or services that do not satisfy all criteria of “medically necessary” items or services, as defined in the statute or in the Medical Necessity rule chapter at 1200-13-16.

**Medically Needy.** A category of TennCare Medicaid eligibles as defined in rule 1240-3-2-.03 of the Tennessee Department of Human Services – Division of Medical Services. The Medically Needy category in Tennessee is limited to pregnant women and children.

**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 ramp, 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.

**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](http://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 C.F.R. § 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 the SSD category is open and applications for that category are accepted.

**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 to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with ADLs (see Activities of Daily Living) and/or assistance with IADLs (see Instrumental 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 those enrolled in the CHOICES program and receiving HCBS, which enables certain individuals at high risk of institutionalization 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 enrollee'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 enrollee'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 to 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, its 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.<sup>4</sup>

**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, 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 — pregnant women; women identified by the Centers for Disease Control and Prevention (CDC) as being uninsured 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.** The condition of having all available and appropriate policies in place to ensure that the overall TennCare program is operating effectively and efficiently, including but not limited to preventing fraud and abuse from occurring in the first place and taking appropriate corrective action when fraud or abuse does occur.<sup>5</sup>

**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 TennCare in order to stay on the program.

**Reduction, Suspension, or Termination of Benefits.** The acts or omissions by TennCare or others acting on its behalf (i.e., 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.

**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.

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<sup>4</sup> The *2011 Poverty Guidelines* can be found at the following website:  
<http://www.cms.gov/MedicaidEligibility/Downloads/POV11Combo.pdf>

<sup>5</sup> Wachino, V., "The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid." Kaiser Commission on Medicaid and the Uninsured, June 2007.

**Resources.** Assets such as savings accounts, personal property, etc., which are available to an individual. Resources are not counted for Medically Eligible children in the Demonstration population. For 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 eligibles do not get automatic periods of retroactive eligibility in Tennessee 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.

**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 2 participant 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 participant is reasonably expected to be discharged and to resume HCBS participation within 90 days.

**Single Point of Entry (SPOE).** TennCare or its designee responsible for screening individuals wishing to enroll in the CHOICES program, using the tools and protocols specified by TennCare 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 TennCare program. Only CHOICES applicants 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 Medicaid Medically Needy program, which is an optional eligibility category that states may choose to cover in their Medicaid programs. (See 42 CFR 436, 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 covers pregnant women and children to age 21 in its Medicaid Medically Needy program.

**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 Medicaid Medically Needy program.

**State Plan.** A Medicaid State 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 MR 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 Care (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. The provision of this allowance is at the sole discretion of the MCO and is provided as a cost-effective alternative to a covered service in order to facilitate transition from a Nursing Facility to a community setting.

**Transitional Medicaid.** The availability of continuing Medicaid coverage for a period after an individual has ceased receiving benefits under the Families First (TANF) program.

**Uninsurable.** Under TennCare I, a person who did not have insurance, who did not have access to insurance other than Medicare, and who had been turned down for insurance because of a health condition. This category was replaced by “Medically Eligible” in TennCare II.

**Uninsured.** A person who is not insured and who lacks access to group health insurance.

**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 Terms

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

**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 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 four Demonstration populations in TennCare Standard. These populations are identified in Chapter 2 of the Operational Protocol.

**TENNCARE CHOICES** is the program that provides long-term care services through TennCare's managed care delivery system. The purpose of CHOICES is to demonstrate that long-term care services 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.



# TENNCARE OPERATIONAL PROTOCOL

## CHAPTER 1: Overview



## Section 1.1

### Explanation of TennCare as a Medicaid “Demonstration” Project

TennCare is a Medicaid “Demonstration” Project.

“Medicaid,” first of all, is a program jointly funded by the state and federal governments to provide certain defined benefits to persons meeting specified Medicaid 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. Medicare and Medicaid are different programs, although 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. It is different from other state Medicaid programs, however, in that it operates under certain “waivers” of federal regulations to “demonstrate” a specific health care premise—namely, that a state can generate sufficient savings through the use of a managed care approach to be able to extend coverage to people who are not otherwise Medicaid-eligible without spending more money than the state would have spent under its Medicaid program. There are other states that offer Medicaid demonstration programs, but each Demonstration is unique.

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 eligibility to persons who would not otherwise be Medicaid-eligible.

“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 twice by CMS and is currently in effect through June 30, 2013.

In March 2010, TennCare began implementation of an important new component of TennCare II called TennCare CHOICES in Long-Term Care (CHOICES). This program was developed as a result of 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 care services 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 who would otherwise require nursing facility care. These options allow eligible individuals to remain in their homes and communities rather than having to enter nursing facilities. CHOICES was implemented in Middle Tennessee on March 1, 2010. Implementation of CHOICES in East and West Tennessee began August 1, 2010. Under CHOICES, eligible TennCare enrollees receive long-term care services, nursing facility and/or 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 various materials, such as TennCare benefits, eligibility categories, etc. It is not an exhaustive compilation of materials, nor is it a legal document.

It is important to recognize that there are a number of legal documents that govern the TennCare program. These include:

- TennCare approval materials, specifically the Special Terms and Conditions (STCs), the Expenditure Authorities, and the Waiver List. These materials may be viewed at the following site: <http://www.tn.gov/tenncare/policy.html>. Attachment H to the Operational Protocol is a table of contents 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 TennCare 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 a document required of every state operating a Medicaid program. This document may be viewed at the following site: <http://www.tn.gov/tenncare/pol-stateplan.html>
- TennCare rules, which are filed with the Secretary of State's office. The TennCare rules for both TennCare Medicaid and TennCare Standard may be viewed at the following site: <http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm>
- Court cases affecting TennCare. These may be viewed at the following site: <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 cites will be repeated throughout this Operational Protocol to assist the reader in finding additional resources.

## Section 1.3

### Organizational and Structural Configuration of the Demonstration

The TennCare Demonstration is administered by the Bureau of TennCare, which is a division of 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 of TennCare is headed by a Deputy Commissioner. Divisions within the Bureau include:

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

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

Special Term and Condition (STC) #14 states that TennCare 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 specific 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"> <li>• Performance of TennCare audits</li> <li>• Performance of Managed Care Organization (MCO) audits</li> <li>• Performance of quarterly audits of the implementation of the <i>Grier</i> Consent Decree</li> <li>• Establishment of rates for Nursing Facilities and for Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR)</li> </ul>

<b>Agency</b>	<b>Functions</b>
Department of Children's Services (DCS)	<ul style="list-style-type: none"> <li>• Determination of Medicaid eligibility for children entering state custody</li> <li>• Provision of residential treatment and targeted case management services for TennCare-eligible children in state custody</li> <li>• Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) outreach</li> </ul>
Department of Commerce and Insurance (TDCI)	<ul style="list-style-type: none"> <li>• 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)</li> <li>• Administration of the TennCare Claims Processing Panel and independent Review Process for review of denied claims submitted by providers</li> <li>• Establishment and enforcement of uniform claim form instruction standards</li> <li>• Administration of annual HMO/MCO network adequacy study required by T.C.A. 56-32-131</li> <li>• 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</li> </ul>
Department of Education (DOE)	<ul style="list-style-type: none"> <li>• EPSDT outreach</li> </ul>
Department of Health (DOH)	<ul style="list-style-type: none"> <li>• EPSDT outreach</li> <li>• EPSDT screenings</li> <li>• Provision of dental screenings and services to children</li> <li>• Presumptive eligibility determinations for pregnant women</li> <li>• Presumptive eligibility determinations for uninsured women needing treatment for breast and/or cervical cancer</li> <li>• Enrollee education and advocacy</li> </ul>

<b>Agency</b>	<b>Functions</b>
Department of Human Services (DHS)	<ul style="list-style-type: none"> <li>• TennCare eligibility determinations</li> <li>• Provision of education and assistance regarding the TennCare eligibility process</li> <li>• Family assistance information line</li> <li>• Appeals of eligibility-related issues</li> <li>• EPSDT outreach</li> </ul>
Department of Intellectual and Developmental Disabilities (DIDD)	<ul style="list-style-type: none"> <li>• Provision of home and community based waiver program services</li> <li>• Provision of Self-Determination Waiver Program services</li> <li>• Provision of services related to the Pre-admission and Annual Resident Review</li> </ul>
Department of Mental Health (DMH)	<ul style="list-style-type: none"> <li>• Consultation on the behavioral health component of the TennCare Demonstration Waiver</li> <li>• Obtainment of attestations from psychiatric residential facilities on compliance with CMS standards on the use of seclusion and restraint</li> </ul>

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 others shown in Table 1-2.

**Table 1-2**  
**Major TennCare Administrative Contractors**

<b>Contractor</b>	<b>Major Functions</b>
Hewlett-Packard (HP)	<ul style="list-style-type: none"> <li>• Claims processing for long-term care</li> <li>• Claims processing for Medicare crossover payments</li> <li>• Maintenance of eligibility subsystem</li> <li>• Maintenance of encounter data</li> <li>• Ad hoc and regular reports</li> </ul>
KePRO	<ul style="list-style-type: none"> <li>• Review of medical appeals</li> <li>• Assistance with medical policy</li> </ul>
Volunteer State Health Plan (VSHP)	<ul style="list-style-type: none"> <li>• Administration of TennCare Select contract</li> </ul>
QSource (EQRO)	<ul style="list-style-type: none"> <li>• Quality reviews of MCOs</li> <li>• Special studies</li> </ul>

<b>Contractor</b>	<b>Major Functions</b>
Health Management Systems (HMS)	<ul style="list-style-type: none"> <li>• Estate recovery</li> <li>• Insurance recovery – medical subrogations</li> <li>• Insurance verifications</li> <li>• Review of provider accounts – to determine if overpayments have occurred</li> </ul>

TennCare II operates totally in a managed care environment and uses various types of managed care entities to deliver covered services to TennCare enrollees. Table 1-3 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**

<b>Type of Entity</b>	<b>Balanced Budget Act (BBA) Definition</b>	<b>Description of Services Provided</b>	<b>Reimbursement and Rate-Setting Methodology</b>
Managed Care Organizations (MCOs) – at full risk	MCO	All TennCare physical health, behavioral health, and long-term care services	MCO rates are actuarially certified by an independent third party actuary
TennCare Select – non-risk or partial risk	Prepaid Inpatient Health Plan (PIHP) <sup>6</sup>	All TennCare physical health, behavioral health, and long-term care services for enrollees selected for participation in TennCare Select rather than enrolled in MCOs	Provider payment rates negotiated between the PIHP and providers; administrative fee, approved by CMS, paid to the PIHP
Dental Benefits Manager (DBM) – non-risk	Prepaid Ambulatory Health Plan (PAHP) <sup>7</sup>	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 #38

<sup>6</sup> 42 C.F.R. § 438.2

<sup>7</sup> Ibid.



# TENNCARE OPERATIONAL PROTOCOL

## **Chapter 2: Eligibility and Enrollment**



## Section 2.1 Overview of TennCare Eligibility

This chapter provides a description of the populations covered by TennCare. These include **Medicaid eligibles**, as well as **Demonstration eligibles**.

“Medicaid eligibles” are persons who meet the criteria for one of the Medicaid categories covered by the TennCare program. Medicaid eligibles 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 Medicaid in the absence of the TennCare Waiver, or Demonstration. They are enrolled in TennCare Standard.

It is important to recognize that a person must meet the criteria for a TennCare category in order to be eligible for the program. Medicaid categories are established by federal law, with some categories being **mandatory** for states and some being **optional**. The Demonstration categories, which are not established in federal law, must be formally approved by CMS as part of TennCare’s 1115 waiver. States do not have the option of simply choosing to cover certain people or certain groups of people without explicit federal approval.

The eligibility groups are summarized in Table 2-1 and discussed in more detail in Special Term and Condition (STC) # 17.

**Table 2-1  
Major TennCare Eligibility Categories**

TennCare Categories	Brief Description
<b><i>Mandatory Medicaid Categories</i></b>	
1931 recipients <sup>8</sup>	Persons who meet certain criteria associated with the program that was formerly called Aid to Families with Dependent Children (AFDC), including people losing eligibility for welfare benefits due to income from employment, increased work hours or increased child or spousal support collections.
Infants born to Medicaid-eligible pregnant women	Children who are eligible for Medicaid throughout the first year of life so long as they remain in their mothers’ households and their mothers remain eligible, or would be eligible if they were still pregnant.
Poverty level pregnant and postpartum women	Pregnant and postpartum women with incomes at or below 185% of poverty.
Poverty level infants and children to age 19	Infants under age 1 with incomes at or below 185% of poverty; children from age 1 to age 6 with incomes at or below 133% of poverty; children from age 6 to age 19 with incomes at or below 100% of poverty.

<sup>8</sup> Section 1931 of the Social Security Act was established as part of the 1996 welfare reform law.

<b>TennCare Categories</b>	<b>Brief Description</b>
Children in foster care or adoption subsidy arrangements	Children who receive Title IV-E foster care or adoption assistance and children with special medical needs who receive a non-Title IV-E state adoption subsidy payment.
SSI recipients, including persons in SSI-related groups	Persons with low income who are aged, blind, or disabled.
<b>Optional Medicaid Categories</b>	
Individuals who meet the institutional level of care	Persons receiving care in Nursing Facilities, Intermediate Care Facilities for persons with Mental Retardation, or HCBS waiver programs who have incomes at or below 300% of the SSI Federal Benefit Rate.
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 whose incomes do not exceed 185% 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).
<b>Demonstration Categories (enrolled in TennCare Standard)</b>	
Title XIX Medically Eligible children	Children under age 19 with incomes of 200% of poverty or higher who lose TennCare Medicaid eligibility may "roll over" into TennCare Standard if they lack access to insurance and are determined to be medically eligible for this category.
Title XXI Medicaid Expansion children	Children under age 19 with incomes below 200% of poverty who lose TennCare Medicaid eligibility may "roll over" into TennCare Standard if they lack access to insurance. <sup>9</sup>  <i>(Note: Uninsured children under age 19 with incomes below 200% of poverty who were enrolled in TennCare Standard on December 31, 2001, were "grandfathered" into the Title XXI Medicaid Expansion group even if they have access to other health insurance as long as they remain in this category and do not enroll in the other health insurance.)</i>

<sup>9</sup> Title XXI is the Children's Health Insurance Program. Tennessee's CHIP is referred to as a "combination" program. There is a stand-alone component called CoverKids and a separate Medicaid component. Children in the Medicaid category receive TennCare coverage, but the costs of their services are paid for with Title XXI funds instead of Title XIX funds.

TennCare Categories	Brief Description
Standard Spend Down (SSD) enrollees	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.
CHOICES 217-Like HCBS Group	Aged and/or disabled adults who meet the CHOICES NF level of care requirement, who are receiving HCBS, and who would be eligible in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726 of the federal regulations and § 1924 of the Social Security Act, if HCBS were provided under a 1915(c) waiver.

Source: STC # 17

### **2.1.1 TennCare Medicaid Eligibility**

All persons who would be eligible for Medicaid under the eligibility rules specified in Tennessee’s State Plan for Medical Assistance (provided in accordance with Title XIX of the Social Security Act) are eligible for TennCare.

Eligibility for Medicaid through the Supplemental Security Income (SSI) program is determined by the Social Security Administration (SSA). (SSI recipients are automatically eligible for TennCare.) Eligibility for all other TennCare categories is determined by DHS.

Reference: See Rule 1200-13-13-.02 and STC # 17 (Eligibility)

#### **2.1.1.1 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 the DHS Division of Medical Services Rule 1240-03-03-.02.

#### **2.1.1.2 Access to Insurance**

Unlike some TennCare Standard enrollees, TennCare Medicaid enrollees are not prohibited from having other health insurance. The one exception to this is women in the Breast and/or Cervical Cancer group, who cannot have insurance that covers treatment for their breast and/or cervical cancer. Some enrollees may have health insurance through an employer, or may have purchased health insurance on their own. TennCare Medicaid enrollees are required to assign the benefits of such policies to the State.

#### **2.1.1.3 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. The family income level is calculated by DHS according to the current federal poverty level

(FPL) standards, using definitions of “family” and “income” that are similar to those used for Families First/AFDC cash assistance applicants.

- **Resources** are assets such as cash, bank accounts, stocks, bonds, and property.

Many of the TennCare categories refer to incomes that are certain percentages of the FPL, which is updated annually. A copy of the FPL for the current year can be found at <http://aspe.hhs.gov/POVERTY/>

### **2.1.2 TennCare Standard Eligibility**

Persons who meet the technical and financial eligibility requirements of the TennCare Demonstration categories described in Table 2-1 are enrolled in TennCare Standard. Their eligibility is determined by the Department of Human Services.

#### **2.1.2.1 Technical eligibility criteria**

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

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

#### **2.1.2.2 Access to insurance**

“Access to insurance” remains an important concept in TennCare Standard. Persons in TennCare Standard, other than those who are enrolled in the Standard Spend Down program or the CHOICES 217-Like Group, must lack access to health insurance. If employed, the individual must provide a statement from his employer concerning the 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 uninsured status are presented in Attachment B.

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

#### **2.1.2.3 Financial eligibility**

What is counted as “income” for children in TennCare Standard is the same as that for TennCare Medicaid children. (See Section 2.1.1) Resources are not counted for TennCare Standard children.

Enrollees in the Standard Spend Down program have the same spend down levels and resource requirements as pregnant women and children served in the 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.). Their resources cannot exceed \$2,000 for a family of 1 or \$3,000 for a family of 2.

### **2.1.3 TennCare CHOICES in Long-Term Care (CHOICES) Eligibility**

CHOICES is the program in which Nursing Facility (NF) services for TennCare eligibles of any age and Home and Community Based Services (HCBS) for individuals aged sixty-five (65) and older and/or adults aged twenty-one (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 care to choose between receiving services in their homes or communities and receiving services in a Nursing Facility.

There are two principal eligibility groups in TennCare CHOICES.

- CHOICES 1 is for individuals receiving services in a Nursing Facility. 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) and are receiving HCBS as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or TennCare Standard, if they are not SSI-eligible. Individuals in CHOICES 2 must be age 21 or older.

*Reference: STC # 18 (TennCare CHOICES Eligibility Groups).*

#### **2.1.3.1 Enrollment in TennCare CHOICES**

Enrollment procedures differ depending upon whether the person is already enrolled in TennCare Medicaid. Individuals not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). TennCare has contracted with the Area Agencies on Aging and Disability (AAADs) to serve as the SPOEs across the State.

TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs. They may also be identified through other mechanisms that would trigger an assessment of their need for long-term care by the MCO.

The effective date of enrollment in TennCare CHOICES is established by TennCare based on a determination that an applicant is eligible for and can begin receiving long-term care services.

#### **2.1.3.2 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. There will not be an enrollment target for CHOICES 1. An initial enrollment target of 7,500 for CHOICES 2 was established by TennCare beginning March 1, 2010. Effective July 1, 2010, the enrollment target was changed to 9,500, and effective September 30, 2011, the enrollment target was increased to 11,000.

Once the enrollment target for CHOICES 2 is reached, TennCare may not enroll additional individuals in CHOICES 2 except as described below. A CHOICES Waiting List as described in Section 2.1.3.6 may be established when there is an insufficient number of slots to accommodate those wishing to receive HCBS through CHOICES 2.

### **2.1.3.3 HCBS as a cost-effective alternative**

An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll that individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care. The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. This person 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.

### **2.1.3.4 Transition from CHOICES 1 to CHOICES 2**

An enrollee being served in CHOICES 1 who meets the requirements to enroll in 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.

### **2.1.3.5 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 in imminent risk of being placed in a NF absent the provision of HCBS.

### **2.1.3.6 Waiting lists for TennCare CHOICES**

The use of an enrollment target for CHOICES 2 as described above may mean there will be a waiting list for CHOICES 2. (There will not be a waiting list for CHOICES 1.) The waiting list will be managed on a statewide basis using a standardized assessment tool and in accordance with criteria established by TennCare. The waiting list is based on objective criteria and is applied consistently across the State.

### **2.1.3.7 Consumer direction**

CHOICES members who have been determined by their MCO care coordinator, as part of the needs assessment and plan of care processes, to require attendant care, personal care visits, homemaker services, in-home respite care, or companion care, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E of the STCs.

*Reference: See STCs # 18 (TennCare CHOICES Eligibility Groups), # 21 (Adult Non-State Plan Demonstration Population Categories), # 34 (Operation of the TennCare CHOICES Program), and Attachment E (Best Practices Guidance Regarding Consumer Direction of Home and Community Based Services). TennCare Rule 1200-13-01-.05.*

### **2.1.4 TennCare and Medicare Eligibility**

Some Medicare beneficiaries are also eligible for Medicare cost-sharing and premium assistance from TennCare. Individuals who have Medicare and are also TennCare-eligible 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 TennCare.
- **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 TennCare.
- **Other Medicare/TennCare duals.** These are Medicare beneficiaries who do not belong in any of the above categories but who also qualify for TennCare.

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

*Reference: See TennCare Rule 1200-13-17.*

### **2.1.5 Aliens and Refugees**

Qualified aliens, including refugees, continue to be eligible for TennCare if they meet Medicaid eligibility criteria. They are enrolled in MCOs in the same manner as all other TennCare enrollees. Emergency services for undocumented aliens continue to be 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>

## Section 2.2 TennCare Application Process

### **2.2.1 Overview: Applying for TennCare Medicaid**

Persons meeting Medicaid eligibility criteria can enroll at any time. SSI applicants apply through the Social Security Administration (SSA) and are automatically enrolled in TennCare Medicaid upon approval of SSI benefits. Children coming into State custody are enrolled through the Department of Children's Services. They have access to an arrangement called "immediate eligibility," which is discussed in Section 2.2.7.

Pregnant women can apply for presumptive eligibility at local health departments and other sites designated by the Department of Health through the State's Title V agreement.<sup>10</sup> If they meet the requirements for presumptive eligibility, they become immediately eligible for TennCare coverage. During a period of presumptive eligibility, a woman must complete an application with DHS, and then be determined eligible for continued enrollment in Medicaid beyond the presumptive eligibility period.

Women who are under age 65, who are uninsured or have insurance that does not cover treatment for breast or cervical cancer, and who have been determined to be in need of treatment for breast or cervical cancer, may be screened for presumptive eligibility for Medicaid by a Centers for Disease Control and Prevention (CDC) site such as the health department. During the presumptive eligibility period, the woman must go to the DHS office to complete her application for enrollment in Medicaid. The DHS worker first evaluates the woman to determine if she is eligible for any other Medicaid category. If she is not eligible in another Medicaid category, the worker evaluates her for this optional Medicaid category to cover her during the time she needs treatment for cervical or breast cancer.

Applicants, other than SSI applicants, usually complete a portion of the application prior to the actual face-to-face or telephone interview. During the interview, the DHS worker and the applicant jointly complete the remainder of the application. Persons who are unable to complete the applicant sections of the full application are assisted by DHS workers during the interview process (see Section 2.2.9). Applicant information is keyed online during the interview (in most cases) or from a workbook manually completed by a DHS worker at a later time (only occasionally).

An online application is now available for people who want to apply for TennCare. It is accessible through both the TennCare website and the website for the Department of Human Services. Following the receipt of the electronic application, DHS will contact the applicant about scheduling an interview and obtaining any additional information that may be needed.

*For access to the online application:*

TennCare's website: <http://www.tn.gov/tenncare/>

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<sup>10</sup> Title V of the Social Security Act is a federal-state partnership that authorized the creation of the Maternal and Child Health programs, thereby providing the foundation and structure needed to meet the nation's goals for healthy mothers and children. OBRA 1989 converted the Title V program into a block grant program, consolidating seven categorical programs.

DHS' website: <http://www.tn.gov/humanserv/>

The State's automated eligibility system (ACCENT) determines Medicaid eligibility by category based on the information entered. Medicaid eligibility is determined within the time periods provided for in federal regulations, and the applicant is notified by DHS of the result of this process. Appeals of denials of Medicaid eligibility are handled by DHS.

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

## **2.2.2 Overview: Applying for TennCare Standard**

This section provides information about applying for TennCare Standard.

### **2.2.2.1 Uninsured child eligibility**

Children under age 19 whose Medicaid eligibility is ending are screened for TennCare Standard. If a child lacks access to insurance and has income below the specified poverty level, he may be eligible for the TennCare Standard Uninsured category. If the child meets all the technical eligibility criteria for TennCare Standard and is ineligible solely because of excess income, the child is offered an opportunity to apply in the Medically Eligible (ME) category. Uninsured children who qualify for TennCare Standard will be allowed to move immediately into TennCare Standard as "Medicaid Rollovers." They will not experience a break in coverage.

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

### **2.2.2.2 Medical Eligibility**

Any child under age 19 whose Medicaid eligibility is ending, who is uninsured, and who meets all of the technical requirements for TennCare Standard but has income at or above 200% of poverty will be given an opportunity to apply as Medically Eligible. There are two options that a child may use to apply for coverage in the Medical Eligibility category:

- Based on claims information, the Bureau of TennCare may determine that a child has a medical or behavioral condition that indicates he is medically eligible for TennCare.
- 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),<sup>11</sup> or the child must submit, along with the completed application, appropriate medical records<sup>12</sup> to support the attestation of a medical condition *not* included on the TennCare list, and a release for additional medical records, if necessary.

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<sup>11</sup> The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring and/or treatment. Due to the severity of these diseases/conditions, most Tennessee insurance companies will deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.

<sup>12</sup> "Medical records" are defined in Tennessee Code Annotated (T.C.A.) 63-2-101(c)(2) 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.

Each of the methods above requires the child to include with the completed application all supporting documentation. Only complete applications accompanied by the required supporting documentation will be processed.

Medically Eligible TennCare Standard enrollees must renew their TennCare eligibility on the same schedule as other TennCare enrollees. Renewing TennCare eligibility means updating information on income, family size, access to insurance, etc. However, the medical criteria for Medical Eligibility will not be verified annually for those who remain on the program without a break in coverage.

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

### **2.2.2.3 Standard Spend Down (SSD) eligibility**

The SSD eligibility 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.

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

When an “open enrollment” period is announced, DHS will establish a telephone “Call-In Line” as a single point of entry for those who think they may qualify for SSD. Calls will be accepted up to the point that DHS estimates it can process applications within Federal timeliness standards. Callers to the Call-In Line will be asked for simple demographic information and will be assigned a unique identifier. DHS will first determine whether or not the caller is already enrolled in TennCare Medicaid. If not, DHS will mail an application form with a letter instructing the caller to complete the form and return it within 30 days to be considered for enrollment. Callers who are determined to be already enrolled in TennCare Medicaid as Medicaid State Plan eligibles will be sent a letter informing them that they currently have benefits and that they do not need to apply. Additional information about enrollment in TennCare Standard Spend Down is found in Part III of Section XIII of the STCs.

*Reference: See Section XIII – Part III (Enrollment in TennCare Standard Spend Down) of the STCs, and TennCare Rule 1200-13-14-.02.*

### **2.2.2.4 CHOICES 217-Like HCBS Group eligibility**

The CHOICES 217-Like HCBS Group is composed of persons age 65 and older or adults age 21 and older with physical disabilities who:

- Meet the NF level of care requirement;
- Are receiving HCBS; and
- Would be eligible in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726, and § 1924 of the Social Security Act, had the State continued its 1915(c) HCBS waiver for individuals who are elderly and/or physically disabled. (With the statewide implementation of CHOICES, the Bureau no longer provides HCBS for the elderly and disabled under a Section 1915(c) waiver.)

An individual who is not currently enrolled in TennCare and who wishes to apply for CHOICES 2 for HCBS must contact the Single Point of Entry (SPOE) in his area. The SPOE is the Area Agency on Aging and Disability (AAAD). 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, DHS will make a determination of whether the individual meets the criteria of the Institutional category of eligibility or some other Medicaid category. DHS will also determine the patient liability and whether any transfer of assets that may have occurred meets the requirements of the Deficit Reduction Act (DRA).

A current TennCare Medicaid enrollee who wants to participate in the CHOICES 2 program for HCBS must contact his MCO for a determination of eligibility for these services, i.e., appropriateness of receiving care in the home and whether the cost of services fits within the budget neutrality requirement. A person who is already Medicaid-eligible shall not be required to file a new Medicaid application to qualify in an Institutional category (e.g., 217-Like Demonstration population). Only additional information needed by DHS to determine whether the person meets Institutional eligibility requirements and to calculate patient liability and assess transfer of assets under the DRA shall be required. Such information shall be submitted by the MCO as an attachment to the CHOICES Enrollment Form.

The Bureau can make a preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group. This determination of "immediate eligibility" allows enrollment in CHOICES Group 2 and immediate access to a limited scope of HCBS, while waiting for a final determination of eligibility. The qualifications for immediate eligibility in CHOICES are found in TennCare rule 1200-13-01-.02. Immediate eligibility shall only be for specified HCBS (no other covered services) and for a maximum of 45 days. (See Section 2.2.7 below.)

*Reference: STC # 21(b) Adult Non-State Plan Demonstration Population Categories) and TennCare rule 1200-13-01-.05 and TennCare Standard rule 1200-13-14-.02.*

### **2.2.3 Effective Date of Eligibility**

The date an individual's TennCare coverage begins varies depending 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**

<b>Program</b>	<b>Eligibility Category</b>	<b>Effective Date of Eligibility</b>
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 at any alternative site designated by the Centers for Disease Control and Prevention.

<b>Program</b>	<b>Eligibility Category</b>	<b>Effective Date of Eligibility</b>
TennCare Medicaid	All other Medicaid eligibles	The date of the application (the date a signed original or faxed application is received in the county DHS office) or the date of the qualifying event (such as the date that a spend down obligation is met), whichever is later.
TennCare Standard	Uninsured children under 19	The date of the application (the date a signed original or faxed application is received in the county DHS office). TennCare Standard coverage typically begins the day after TennCare Medicaid coverage ends.
TennCare Standard	SSD eligibles (Call-in Group) – see Part III of Section XIII in the STCs	The date the call was received by DHS 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.
TennCare Standard	CHOICES 217-Like Group	The date the application is approved by DHS or the date the Bureau grants “immediate eligibility” pursuant to Rule 1200-13-01-.05(3)(f).

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

#### **2.2.4 Length of Eligibility Period**

Once eligibility is established, it lasts until a redetermination occurs. There are certain categories of eligibles that have automatic eligibility periods. These are as follows:

- **Pregnant women and newborns.** Pregnant women have TennCare Medicaid coverage for the length of their pregnancy, plus two months postpartum. The newborn is automatically given one year’s eligibility in TennCare Medicaid if the mother was TennCare Medicaid-eligible on the day of birth. The newborn is placed in the same MCO as the mother unless the mother is in TennCare Select. In that situation, the child goes through the random assignment process.
- **Women receiving treatment for breast and/or cervical cancer.** A woman in this category remains eligible until 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, or she gains health insurance that provides coverage for treatment of breast and/or cervical cancer, or she turns 65 years old.

- **SSI beneficiaries.** Those individuals who are enrolled in TennCare Medicaid because they receive SSI benefits from the Social Security Administration remain TennCare-eligible for as long as they are eligible for SSI.
- **Medically Needy and SSD enrollees.** These enrollees get an automatic year of eligibility, unless there are changes in their circumstances impacting eligibility for TennCare.

Changes in income, family status or living circumstances (including address changes) that occur in the interim periods between “begin” and “end” dates of coverage must be reported by the enrollee to his DHS worker within 10 days if the enrollee has TennCare Medicaid or 30 days if the enrollee has TennCare Standard. Failure to report such changes in a timely manner may result in termination from the program.

*References: See Rules 1200-13-13-.02 and 1200-13-14-.02.*

### **2.2.5 Re-Establishment of Eligibility**

Eligibility in all TennCare categories includes a “begin date” and an “end date.” A person may remain on TennCare past his end date only if he is determined eligible through the redetermination process. All TennCare enrollees must re-establish their ongoing eligibility for TennCare on at least an annual basis. *Ex parte* reviews<sup>13</sup> conducted by DHS, responses to Request for Information (RFI) notices, and/or interviews between the DHS 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.

For women receiving treatment for breast and/or cervical cancer, redetermination of TennCare eligibility occurs at least every 12 months and is based on the need for continuing treatment for the breast or cervical cancer, as determined by the woman’s treating physician. It is the need for continuing treatment of the breast or cervical cancer that is the determining factor, not any specified period of months or years or the need for treatment of any other medical condition. Women who are determined to need surveillance only (i.e., those who are not receiving cancer chemotherapy, hormonal therapy, radiation therapy, or surgery) are not considered to be in need of “treatment.” TennCare’s Office of the Chief Medical Officer is responsible for reviewing the information submitted by the woman’s physician.

The determination that an individual meets the medical criteria for Medical Eligibility for TennCare Standard will not be reverified every year, since most of the conditions are chronic conditions that are life-long. However, such an individual may be required, on occasion, to submit proof of continued medical eligibility during the redetermination process. Children who are Medically Eligible will still have to renew their TennCare coverage each year and provide updated information on residency, changes in income, and access to group health insurance.

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

### **2.2.6 Rollover Eligibility for Individuals under Age 19**

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<sup>13</sup> An “ex parte review” is one done without the presence of the enrollee. DHS 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.

If an enrollee under the age of 19 loses eligibility for TennCare Medicaid, he may apply for TennCare Standard and, if eligible, be enrolled in TennCare Standard, unless the loss of eligibility is due to incarceration or non-resident status. People who enroll in this way are called "Medicaid Rollovers." (Persons who lose eligibility because they are incarcerated or who move permanently out of state are not eligible to continue on TennCare as Medicaid Rollovers.)

Enrollees who are children under the age of 19 moving from Medicaid to TennCare Standard will receive the same benefits as were included in their TennCare Medicaid benefit package. They will also be subject to copayment requirements as described in Section 3.2 – TennCare Cost Sharing. Thereafter, these enrollees must reestablish eligibility for TennCare Standard at announced intervals, which will occur at least once within a 12-month period.

*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).*

### **2.2.7 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. Presumptively eligible pregnant women have 45 days to complete the full eligibility determination process. During the presumptive period, the woman is considered to be a "temporary" Medicaid enrollee; if she does not go to DHS and become eligible in a Medicaid category, she will not be permitted to stay on TennCare when her presumptive period ends.

**Women needing treatment for breast and/or cervical cancer.** Women who are under age 65, who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, and who have been screened at a Centers for Disease Control and Prevention (CDC) site and determined to be in need of treatment for breast or cervical cancer, may be determined to be presumptively eligible for Medicaid at the CDC site. Such individuals must then report to their county DHS office for determination of eligibility beyond the presumptive eligibility period. Coverage in this category is limited to the period during which a woman requires treatment for the breast or cervical cancer.

**Children.** There is no presumptive eligibility for children, except that children entering State custody are deemed "immediately eligible" for TennCare while their TennCare applications are being processed. Should the result of the eligibility determination process be that the children are not eligible for TennCare, DCS will reimburse TennCare Select for any dollars spent on these children's behalf.

**CHOICES applicants.** Immediate eligibility under CHOICES is a mechanism by which the State can, based on preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered HCBS, be determined by TennCare to meet the nursing facility (NF) level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES 2 based on the review of the financial information provided by the applicant. Immediate eligibility shall only be for specified HCBS (no other covered services) and for a maximum of 45 days.

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

### **2.2.8 HIPAA Statement of Coverage**

Enrollees losing eligibility for TennCare 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 Family Assistance Service Center at 1-866-311-4287.

### **2.2.9 Newborns**

TennCare coverage is automatically granted to any infant born to a Medicaid-eligible mother, effective on the date of birth. If a newborn's mother is TennCare Standard-eligible, the child will *not* be automatically granted eligibility for TennCare Standard. The child must be determined Medicaid-eligible in his own right in order to qualify for TennCare.

The newborn will automatically be 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. Parents or family representatives must take steps to have the infant enumerated for Social Security purposes, however, so that he will not fail the TennCare technical eligibility requirement that every enrollee have a valid Social Security Number.

For newborns, a hospital worker may provide to the mother, family member, or a family representative an SS-5 Form (which is an application for a Social Security number/card) to complete for the purpose of obtaining a Social Security number for the newborn. The hospital worker or a DHS worker may assist in completing the SS-5 Form. DHS is allowed to bypass the requirement that the newborn be enumerated if there is verification that an SS-5 Form has been completed.

The MCO in which the mother is enrolled at the time of delivery will be responsible for the coverage and payment of all TennCare-covered services provided to the newborn, beginning at birth. New mothers may voluntarily present to their DHS worker for an assessment of Medicaid eligibility for their child at any time and, in fact, are encouraged to do so.

When a pregnant woman who is an undocumented alien qualifies for TennCare payment of the delivery of her newborn, the newborn is deemed eligible for one year of Medicaid coverage.

*Reference: See DHS Rule 1240-03-02-.02.*

*Policy Statement: CON 08-002 Assignment of Newborns, Coverage and Billing*

<http://www.tn.gov/tenncare/forms/con08-002.pdf>

## **2.2.10 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 been meeting 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 reaching enrollees with disabilities or limited English proficiency. These are issues that are important to both TennCare and patient 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 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 MCCs 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.

### **2.2.10.1 Individuals with limited English proficiency (LEP)**

Both the Bureau of TennCare and the Department of Human Services (DHS) have made a number of provisions to assist individuals with LEP as they navigate the TennCare eligibility processes and the TennCare Program.

Both agencies offer applications in English and Spanish. TennCare mails enrollee notices in English and Spanish, and DHS mails its notices in English or Spanish, depending on what the individual has indicated is his primary language. 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 the Family Assistance Service Center. Individuals who call the telephone number can be connected with the AT&T Language Line for translation services (for approximately 140 languages), if necessary.

The Bureau of TennCare also 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 translation services to TennCare enrollees and applicants. TNCSA can also direct enrollees and applicants to local community translation resources.

DHS also provides translation services, through bilingual staff, a contract with the AT&T Language Line, and contracted and volunteer community translators.

Both the Bureau of TennCare and DHS maintain access to text telephones for the hearing impaired, and DHS has sign language interpreters and readers for the visually impaired on contract.

### **2.2.10.2 People 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.

DHS has performed eligibility determinations for Medicaid, Food Stamps, and its Families First program for many years. The Department makes a number of accommodations available to the TennCare population. These accommodations include:

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

### **2.2.11 MEQC**

TennCare has a contract with the Department of Human Services to conduct Medicaid Eligibility Quality Control (MEQC) Projects on behalf of the single state agency.

At least annually, the State is required to submit a plan for a MEQC pilot project to the CMS Regional Office. When each pilot is complete, the State is to send a report to the CMS Regional Office, and to submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy. This is done in compliance with the waiver STC # 25.

*Reference: See STC # 25 (Quality Review of Eligibility).*

## Section 2.3 Enrollment Process

### **2.3.1. 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 in his area. All family members on the same DHS case must enroll in the same MCO, except for individuals eligible to enroll in TennCare Select. Applicants who fail to select an MCO at their DHS interview are assigned to one that is available in the area in which they live. Once enrolled, TennCare eligibles have 45 calendar days (inclusive of mail time) from the date of the MCO assignment notification letter to change MCOs if they are dissatisfied with their assignment for any reason. After the 45-day change period, 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. If the applicant is subsequently approved for TennCare Medicaid or TennCare Standard, enrollment in the MCO will be effective on the same day that coverage in the program becomes effective.

Individuals who are returning to TennCare after a lapse in eligibility will be reassigned to their former MCO if the lapse lasted for less than 63 days. This assignment is an initial assignment only; members are given 45 calendar days (inclusive of mail time) from the date of the letter informing them of their re-enrollment in TennCare 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.

TennCare 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 the assignment of a particular enrollee 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 contracts to provide covered services to enrollees. Attachment D also lists the Dental and Pharmacy contractors currently participating in TennCare.

*Reference: See TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.*

### **2.3.2 Procedures for Enrollment into TennCare Select**

TennCare Select is a special Managed Care Contractor that operates statewide to serve certain enrollees identified by TennCare. TennCare Select is not an MCC that an enrollee can choose; rather, the State assigns certain enrollees to TennCare Select. These enrollees include:

- 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 persons with Mental Retardation (ICF/MR). Children and adults currently enrolled in an HCBS MR 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.
- Enrollees living out of state temporarily.

SSI-eligible children and children in NFs or ICFs/MR can opt out of TennCare Select if they wish and choose an MCO that serves the area where they live. 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 # 40 and TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.*

### **2.3.3 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 with these contractors.

*Reference: See STC # 39 (Enrollment in Managed Care Organizations (MCOs)), and TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.*

### **2.3.4 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 once each year 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. Thereafter, an MCO change is permitted only during the annual change period unless the Bureau authorizes a change as a result of a request for a hardship change, or 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 request to change MCOs 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.

Enrollees, after requesting and obtaining the approval of the Bureau of TennCare, 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.

An enrollee must change MCOs if he moves outside his assigned MCO's Grand Division and his assigned MCO does not operate in the enrollee's new area of residence. Until the enrollee selects or is assigned to a new MCO, his medical care is the responsibility of the original MCO.

In the event an MCO withdraws from participation in TennCare and is no longer available, TennCare will randomly distribute the membership across the remaining plans available in the MCO's Grand Division(s). 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 # 41, 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; and
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may use choice of providers, regardless of network providers.

*Reference: See STC # 41 (Plan Enrollment and Disenrollment) and TennCare Rules 1200-13-13-.03 and 1200-13-14-.03.*

### **2.3.5 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 2.4 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 are prior approved in writing by TennCare.

### **2.4.1 Marketing Activities and Restrictions**

Marketing guidelines are included in the Managed Care Organization contracts. Key points are summarized below.

Each MCO must submit a detailed marketing plan, all marketing materials, and a description of marketing activities to TennCare 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 and Spanish and in the language of any other Limited English Proficiency group identified by TennCare that constitutes five percent of the TennCare 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.

## **2.4.2 Monitoring of Enrollee Marketing Activities**

The primary focus of monitoring activities is to assure that marketing materials are clearly written and include content that is both correct and appropriate. TennCare also permits MCOs to conduct various outreach activities like health fairs. Plans for these activities also require TennCare 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.

### **2.4.2.1 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. TennCare 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 TennCare.

### **2.4.2.2 Failure to adhere to contractual marketing guidelines**

If TennCare believes that violations of the marketing guidelines have occurred, an informal investigation will be conducted and TennCare staff 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.



# TENNCARE OPERATIONAL PROTOCOL

## Chapter 3: Benefits and Cost-Sharing



## Section 3.1 Benefits

### **3.1.1 TennCare Benefits**

The benefits available to TennCare enrollees are listed in the TennCare Rules for TennCare Medicaid and TennCare Standard and are available on the Bureau's website. Definitions of specific services 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 # 30 (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 care<sup>14</sup>
- 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

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<sup>14</sup> Home health benefits are limited for adults as follows: Part-time or intermittent nursing services must be no more than 1 visit/day, lasting less than 8 hours, and no more than 27 total hours of nursing care per week. Part-time or intermittent nursing services are not covered if the only skilled nursing function is administration of medication on an as needed basis. Home health aide services must be provided at no more than 2 visits/day, with care provided less than or equal to 8 hours/day. Nursing services and home health aide services combined must total less than or equal to 8 hours/day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 nursing care. See TennCare Medicaid rule 1200-13-13-.01 and TennCare Standard rule 1200-13-14-.01.

- Physical therapy services
- Physician services
- Private duty nursing services<sup>15</sup>
- Psychiatric inpatient facility services
- Psychiatric rehabilitation services
- Reconstructive breast surgery
- Renal dialysis clinic services
- Speech therapy services
- Vision services (for children under age 21)

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

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

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

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

*Reference: See STCs # 30 (TennCare Benefits) & # 31 (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 TennCare. A list of the categories of dual eligibles and a description of each category are presented in Section 2.1.4.

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

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<sup>15</sup> Private duty nursing services for adults are covered only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. See TennCare Medicaid Rule 1200-13-13-.01 and TennCare Standard Rule 1200-13-14-.01.

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

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

### **3.1.3 TennCare CHOICES Benefits**

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

These benefits are in addition to the benefits that are available to 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 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.

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

The CHOICES 2 category is for persons age 65 and older or adults age 21 and older with physical disabilities, who meet the NF level of care (LOC) criteria, who qualify as SSI recipients or as members of the 217-Like Demonstration population,<sup>16</sup> and who need and are receiving HCBS as an alternative to NF care.

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

<b>Benefit</b>	<b>CHOICES 1</b>	<b>CHOICES 2</b>
Nursing facility care	X	Short-term Only
Community-based residential alternatives		X
Personal care visits (up to 2 visits per day)		X
Attendant care (up to 1,080 hours per calendar year)		X
Homemaker services (up to 3 visits per week)		X
Home-delivered meals (up to 1 meal per day)		X
Personal Emergency Response Systems (PERS)		X

<sup>16</sup> "217-Like" refers to the CHOICES 217-Like HCBS Group, who will be enrolled in TennCare Standard, consisting of individuals aged 65 and older or individuals age 21 and older with physical disabilities who meet the nursing facility level of care criteria and who could have been eligible for HCBS had the State continued its 1915(c) HCBS waiver for the elderly and/or physically disabled. The "217" comes from 42 CFR § 435.217 which refers to eligibility for an HCBS waiver. See STC # 21(b).

<b>Benefit</b>	<b>CHOICES 1</b>	<b>CHOICES 2</b>
Adult day care (up to 2,080 hours per calendar year)		X
In-home respite care (up to 216 hours per calendar year)		X
In-patient respite care (up to 9 days per calendar year)		X
Assistive technology (up to \$900 per calendar year)		X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X
Pest control (up to 9 units per calendar year)		X

*See STC # 30h 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 Department of Human Services at the time the individual applies for TennCare and any time a TennCare enrollee's income changes.<sup>17</sup>

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

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

*Reference: See TennCare Rules 1200-13-13-.05 and 1200-13-14-.05 and STCs # 35 (Cost Sharing) and # 36 (Co-payments).*

### **3.2.1 Pharmacy Copays**

A pharmacy copay of \$3.00 for brand name drugs applies to the following populations:

- Non-exempt TennCare Standard enrollees with incomes at or above 100% of poverty who are eligible for pharmacy services
- Non-exempt TennCare Medicaid adults (age 21 and older)

The following services are exempt from TennCare copays for all TennCare enrollees:

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

The following TennCare groups are exempt from TennCare copays:

- 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

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<sup>17</sup> Enrollees must report any changes in income to their DHS caseworkers at the time such change occurs. Information about documentation to be supplied and the reporting of changes is provided in *Tennessee Code Annotated (T.C.A.)* 71-5-110.

- Enrollees who are receiving services in Nursing Facilities, Intermediate Care Facilities for persons with Mental Retardation, the CHOICES program, 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

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

*Reference: STC # 36 (Copayments) and TennCare Medicaid Rules 1200-13-13-.01(41) & 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.

Non-pharmacy copays do not apply to following services:

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

**Table 3-3  
Current TennCare Standard Non-Pharmacy Copay Schedule**

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

*Reference: STC # 36 (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 enrollees. One of the conditions of provider participation in TennCare 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 a TennCare enrollee. One is when the service requested is not covered by TennCare and the provider informed the enrollee, prior to providing the service, that it is not covered. The other is when the service requested, such as a sixth prescription within a month's time, exceeds an established benefit limit. The procedures to be followed in either of these circumstances are outlined in TennCare 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 circumstances in which providers cannot seek payment from a TennCare 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 enrollees have other insurance, which can be an important resource in paying for at least a portion of the TennCare services these enrollees receive. Other insurance is referred to as "Third Party Liability" or TPL. Recognition and capture of TPL are critical components in TennCare's efforts to use resources wisely and thereby 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 TennCare automatically assigns his right to collect TPL to the "State" (TennCare), which has delegated this authority to the MCOs. When an enrollee has third party liability (TPL), that third party must be billed before the provider submits the bill 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. 2.21.4.5*

### **3.3.2 Subrogation**

When an insurance company or another person owes money to a TennCare enrollee because of an injury or illness, Federal and State law provides that the State, through the Bureau of TennCare 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 TennCare and/or one of its MCOs paid for an enrollee's service and the enrollee later receives a payment related to the injury or illness, TennCare 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.



# TENNCARE OPERATIONAL PROTOCOL

## Chapter 4: Service Delivery



## Section 4.1 Overview of Managed Care Entities

### **4.1.1 Managed Care Organizations (MCOs) other than TennCare Select**

All TennCare enrollees now receive their physical health services, mental health and substance abuse services, and most long-term care services 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:

- TennCare MCOs must contract with at least two Centers of Excellence (COEs) for people with HIV/AIDS in each of the Grand Divisions in which they operate;
- TennCare MCOs must have contractual arrangements with all COEs for Behavioral Health located within the Grand Division(s) that they serve;
- MCOs must provide adequate numbers of specialty providers (specialists) for the provision of covered services to ensure adequate provider availability for their members. MCOs are encouraged to contract with FQHCs, Community Mental Health Agencies (CMHAs) and other safety net providers (e.g., rural health clinics) in their service areas 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 their service areas; and
- MCOs must contract with each local health department in the Grand Division(s) they serve 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 persons with Mental Retardation (ICF/MR). For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation, 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 residing out-of-state; 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 Demonstration 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 arranging for the provision of necessary health care services. 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 # 40 (TennCare Select).*

## 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: Eastern Tennessee, Middle Tennessee, and Western Tennessee (See *T.C.A. § 4-1-201*). MCOs wishing to participate in TennCare must cover at least one of the three geographical grand divisions.



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

### **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.

Each enrollee shall be provided an identification card identifying him as a participant in the TennCare program within thirty calendar days of notification of enrollment in the MCO's plan or prior to the member's enrollment effective date.

### **4.2.5 Member Service and Clinical Performance Standards**

MCOs must assess member satisfaction and access to services using the Consumer Assessment of Healthcare Providers and Systems (CAHPS). In addition, MCOs are

required to measure the percent of member calls to their Customer Lines not answered, including callers who hung up while waiting in the queue. The benchmark is less than five percent (5%) of calls not answered.

All MCOs are also required to report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) data to the State annually. CAHPS and HEDIS performance indicators are compared to national norms and tracked over time to evaluate the effectiveness of quality improvement efforts. 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 must provide primary care case management services to TennCare enrollees. These services include the management of medical care and continuity of care. Primary care providers (PCPs) may include licensed physicians as well as Advanced Practice Nurses and Physician Assistants practicing in accordance with State law. For enrollees with complex medical problems, the MCO may choose to designate the enrollees' attending specialists as PCPs. The PCP is responsible for maintaining enrollee medical records, for performance of reasonable preventive health services, for documenting emergency encounters and medically indicated follow-up, for coordinating hospital and/or institutional discharge planning, and for other services that may be specified in the MCO Contract.

To the extent feasible and appropriate, MCOs must offer each enrollee a choice of PCPs. They must also offer enrollees an opportunity to change PCPs within a time period of no greater than 12 months under normal circumstances. More frequent changes may be permitted when there is good cause.

*Reference: See Rules 1200-13-13-.03 and 1200-13-14-.03.*

#### **4.2.7 Best Practice Network (BPN)**

The Best Practice Network (BPN) is composed of Best Practice Providers (BPPs). 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. One part of the agreement is to provide a medical home for these children by maintaining all health records for each child, regardless of where the care is provided. All providers are required to forward medical records to the BPN PCP so that a comprehensive medical record can be maintained.

#### **4.2.8 Claims Systems and Performance Standards**

MCOs are required to have in place an automated claims payment 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). The MCO must assure that 90 percent (90%) of clean claims for payment of services delivered to a TennCare enrollee are processed within 30 days of receipt of the claim. (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 adjudicates 99.5 percent (99.5%) of claims within 60 days of receipt. The MCO is required 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. The target is 100 percent (100%), with a benchmark of 97 percent (97%) 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)**

##### **4.3.1.1.1 Full risk arrangements**

Unless otherwise directed by contract, all MCOs, other than TennCare Select, 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 care services through their integrated services contract. The rates vary by age and eligibility category.

*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>

##### **4.3.1.1.2 Shared risk arrangements**

The contractor for TennCare Select is reimbursed on a non-capitated basis for services rendered to covered populations and, in addition, by administrative 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. 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:

<b>Shared Risk Initiative</b>	<b>Contribution to Risk</b>	<b>Contribution to Bonus</b>
Medical Services Budget Target	5.0%	5.0%
EPSDT Compliance	5.0%	5.0%

##### **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 set 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**

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 Methodology for Essential Access Hospital (EAH) payments**

#### **4.3.2.2.1 Eligible hospitals**

Hospitals eligible to receive EAH payments include all hospitals licensed to operate in the State of Tennessee excluding the five (5) State Mental Health Institutes and the Critical Access Hospitals (CAHs). The CAHs receive cost-based reimbursement from the TennCare Demonstration and therefore are not eligible for EAH pool payments. The State must make these payments directly to the providers of the services as specified in 42 C.F.R. § 447.10.

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.2 Allocation of the pool to segments of hospitals**

The annual \$100 million (\$25 million quarterly) pool is segmented into four distinct parts as follows. Actual cash disbursements are paid each quarter.

- **Essential Service Safety Net hospitals - \$50 Million (\$12.5 Million quarterly)**

These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.

- **Children's Safety Net hospitals - \$5 Million (\$1.25 Million quarterly)**

These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 years in Tennessee.

- **Free-Standing Psychiatric hospitals - \$2 Million (\$0.5 Million quarterly)**

These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health (TDMH) for the provision of psychiatric hospital services in Tennessee, excluding the State Mental Health Institutes.

- **Other Essential Acute Care hospitals - \$43 Million (\$10.75 Million quarterly)**

These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the CAHs.

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.3 Data**

Calculation of the quarterly EAH payments is based on the most current Joint Annual Report of Hospitals available at the beginning of the State fiscal year for which the quarterly payments are being made.

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.4 Minimum qualifications**

All hospitals, other than free-standing psychiatric hospitals, must be contracted providers with TennCare Select and, where available, at least one other MCO in the TennCare Demonstration. In order to receive a payment, the free-standing psychiatric hospital must be a contracted provider with at least one of the MCOs in the TennCare Demonstration. All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare costs.

- **Minimum qualification for all acute care hospitals:**

Each qualifying hospital must have 13.5 percent (13.5%) or more of its total adjusted days covered by TennCare.

**- OR -**

- A hospital may qualify if 9.5 percent (9.5%) or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.

- **Minimum qualifications for free-standing psychiatric hospitals**

At least 30 percent (30%) of total adjusted days are covered by TennCare.

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.5 Allocations and calculation of points**

**Allocation is based on an assignment of points for:**

- TennCare adjusted days expressed as a percent of total adjusted patient days;
- Bad debt, charity, and medically indigent care expressed as a percent of total expenses.

### **Calculation of points**

- (1) TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:
  - 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
  - 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
  - 2 points – greater than 24.5% and less than or equal to 34.5%;
  - 3 points – greater than 34.5% and less than or equal to 49.5%;
  - 4 points – greater than 49.5%.
- (2) Bad debt, Charity and Medically Indigent (BDCHMI) costs as a percent of total expenses
  - 0 points – less than 4.5%
  - 1 point - greater than or equal to 4.5% and less than 9.5%
  - 2 points - greater than or equal to 9.5% and less than 14.5%
  - 3 points - greater than or equal to 14.5%

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.6 Calculation of amounts of pool payments for hospitals**

These points are then used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate includes all inpatient costs (operating, capital, direct education) but excludes add-ons (indirect education, Medicare Disproportionate Share Adjustment (MDSA), return on equity).

The GHR for Safety Net Hospitals is \$908.52. The GHR for Other Essential Access Hospitals is \$674.11. The points for each qualifying hospital are summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the four pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initial calculated amount is then adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is \$9 million and the total pool for children's hospitals is \$5 million, each hospital's initial calculated amount will be multiplied by \$5 million/\$9 million.

The resulting value will be the amount to be provided to the hospital as an essential access hospital payment for the fiscal year.

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.7 Payments**

Hospitals are paid on a quarterly basis. The initial payment includes all quarters that have ended at the time that the payment is made. All subsequent quarterly payments are made following the end of the quarter. In order to receive a payment for the quarter, all hospitals, excluding free-standing psychiatric hospitals, must be contracted providers with TennCare Select and, where available, with at least one other MCO, and must have contracted with TennCare Select for the entire quarter that the payment represents. For a free-standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the MCOs.

*Reference: See STC # 57e (Essential Access Hospital (EAH) Pool).*

#### **4.3.2.2.8 Disproportionate Share (DSH) payments**

The Tax Relief and Health Care Act of 2006 (TRHCA) established a DSH allotment for Tennessee for federal fiscal year (FFY) 2007, as described at § 1923(f)(6) of the Social Security Act. The relationship between DSH payments made by the State under TRHCA 2006 and the payments from the EAH pool is further specified in the second paragraph of subparagraph (e) of STC # 57. If Congress should establish a DSH allotment for Tennessee for any subsequent federal fiscal year, the State may make DSH payments to hospitals on the basis of a State Plan Amendment (SPA) approved by CMS.

Under the State Plan Attachment 4.19A, hospitals are grouped into five categories:

- Group 1: Essential Service Safety Net hospitals
- Group 2: Children's Safety Net hospitals
- Group 3: Free-Standing Psychiatric hospitals
- Group 4: Other Essential Acute Care hospitals
- Group 5: All other DSH hospitals as defined by Section 1923(b) of the Social Security Act, but not qualifying in one of the above groups

Hospitals will receive payments that vary according to the group in which they are categorized and factors such as TennCare volume and bad debt, charity, and medically indigent care. The State must make these payments directly to the providers of the services as specified at § 1923(i) of the Social Security Act.

*Reference: See STC # 57i (Disproportionate Share Hospital (DSH) Payments).*

### **4.3.3 Special Pool Payments to Critical Access Hospitals (CAH)**

In accordance with the Waiver Special Terms and Conditions (STCs), the State shall make special pool payments to TennCare CAHs. (Payments for services received at CAHs by TennCare enrollees are made by the enrollee's MCC through the normal claims process.) The State's methodology for making these payments and for claiming federal financial participation

(FFP) for the payments is described below. The State must make these payments directly to the providers of the services as specified in 42 C.F.R. § 447.10.

To qualify for payment as a CAH, a hospital must meet the following criteria:

- It must be an acute care hospital located and licensed in the State of Tennessee;
- It must be designated as a CAH by the Tennessee Department of Health; and
- It must contract with an MCO participating in TennCare.

TennCare provides the special pool payments to CAHs under the following terms:

- Payments are limited to specific annual legislative appropriations for which FFP is available;
- In any State fiscal year where reimbursable TennCare costs incurred by CAHs exceed annual appropriations, the equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation; and
- Special pool payments to hospitals are made directly to the hospital by TennCare.

TennCare provides reimbursement to CAHs under the following terms:

**Inpatient services.** Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by CAHs are reimbursed quarterly with interim per diem rates and are cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services are determined with consideration given to payments for TennCare services made to hospitals by MCOs and any special payments to hospitals. Interim rates are calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient CAH services include no more than 15 acute inpatient beds, although an exception to the requirement is made for swing bed hospitals. CAHs are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that no more than 15 beds are used at any one time for acute care.

**Outpatient services.** Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by CAHs will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges with consideration for payments of TennCare services made to hospitals by MCOs and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost settlements.** Cost settlements are determined from provider-submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for CAHs.

**New designations of CAHs.** For new CAHs that qualify after July 1, 2002, the State will begin reimbursement at the rates established on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its CAH designation. At that time, interim rates will be established, and the designation will be confirmed with the Tennessee Department of Health.

**Audit requirements.** Each CAH is required to maintain adequate financial and statistical records that are accurate and sufficiently detailed to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the Joint Annual Report. The provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

*Reference: See STC # 57f (Critical Access Hospital (CAH) Pool).*

#### **4.3.4 Supplemental Pool Payments to Meharry Medical College**

A supplemental pool of \$10 million per Demonstration Year is available to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare-covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by CMS. Before paying the annual pool payment to the providers, the State will provide CMS with a copy of the annual independent audit report. The State must make these payments directly to the providers of the services as specified in 42 C.F.R. § 447.10.

*Reference: See STC # 57g (Meharry Medical College (Meharry) Pool).*

#### **4.3.5 Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPEs)**

Actual costs incurred by government-operated hospitals for the provision of inpatient and outpatient TennCare-covered services for TennCare enrollees and uninsured patients are eligible as CPEs. The State must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare-covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's GME expenditures; any DSH payments received; and other sources (except for local government indigent funds). With regard only to hospital CPEs, the State will report actual CPEs within 12 months after the end of the fiscal year. At that time, the State will revise its FFP claim to reconcile actual CPEs with the CPEs estimates used during the preceding fiscal year.

The State must follow the CPE protocol, as contained in Attachment F of the STCs, which was approved by CMS for use beginning July 1, 2008.

*Reference: STC # 57h (Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPEs)) & Attachment F (Certified Public Expenditures Protocol)*

#### **4.3.6 Unreimbursed Hospital Cost (UHC) Pool**

The purpose of the UHC pool is to address actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each Demonstration Year (DY) from the pool will be determined annually, in a manner defined in STC # 57k.

Hospitals eligible to receive UHC Pool payments include all hospitals licensed to operate in the State of Tennessee, except for the following:

- Critical Access Hospitals (CAHs);
- Public hospitals eligible to certify public expenditures, including State Mental Health Institutes;
- Rehabilitation and long-term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

The Joint Annual Report of Hospitals serves as the data source for determination of qualification for and amount of UHC Pool payments. The reports are submitted to the Tennessee Department of Health (DOH), edited by the DOH, corrected by the hospital, and placed in a final data file for that year by the DOH. Payment amounts for each DY will be based on the final Joint Annual Report from three years prior to the DY.

The calculation of the UHC Pool payment is described in STC # 57k. Each hospital shall receive an annual payment each DY equal to a percentage of its unreimbursed TennCare costs, using the same percentage to calculate each hospital's payment.

TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations. The annual payment to each hospital shall be made in four equal quarterly payments. The total amount of UHC Pool payments made each DY may not exceed \$500 million total computable.

*Reference: STC # 57k (Unreimbursed Hospital Cost (UHC) Pool)*

#### **4.3.7 Public Hospital Supplemental Payment (PHSP) Pool**

The PHSP Pool is for actual cash disbursements paid from a \$70 million (total computable) supplemental pool per DY to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare-covered services provided to TennCare enrollees and uninsured patients. The State must make these payments directly to the providers of services as specified in 42 C.F.R. § 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis,
- Nashville General Hospital at Meharry.

*Reference: STC # 57l (Public Hospital Supplemental Payment (PHSP) Pool)*

## Section 4.4 Encounter Data

### 4.4.1 Overview

This chapter describes encounter data reporting requirements for MCOs, TennCare Select, the Pharmacy Benefits Manager (PBM), and the Dental Benefits Manager (DBM). Each of these Managed Care Contractors (MCCs) is required to submit individual encounter records on a regular basis for services provided to TennCare eligibles. 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 (see Part 6 of the Operational Protocol).

### 4.4.2 Systems Requirements

To ensure the timely submission of accurate encounter data, all TennCare 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). All vendors must successfully complete a readiness review of their information systems that is designed to ensure that their processing system satisfies the functional and informational requirements of TennCare. Each vendor has an access network established with TennCare 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, TennCare MCCs must process 99.5 percent (99.5%) of claims within 60 days of receipt. The TennCare interface standard for data transfers is via a secure FTP, using HIPAA transaction formats.

#### **4.4.2.1 Frequency**

All MCCs (MCOs, DBM, and PBM) participating in TennCare 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 care services, and other medical services are required.

#### **4.4.2.2 Format**

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

<b>Type of Claim</b>	<b>Required Format</b>
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 TennCare. Generally, MCC encounter files are generated as part of the standard

financial cycle and submitted to TennCare, 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.

#### **4.4.2.3 Data integrity**

Upon receipt of encounter data files, TennCare 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. TennCare validates all seven levels of SNIP edits for determining and reporting HIPAA compliance during validation processing.<sup>18</sup>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, TennCare may apply liquidated damages or other intermediate sanctions as specified in the Contractor Risk Agreement.

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<sup>18</sup> 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.



# TENNCARE OPERATIONAL PROTOCOL

## **Chapter 5: Quality of Care**



## Section 5.1 Evaluation Design

### **5.1.1 Program Objectives**

The purpose of the TennCare Demonstration is to establish that a Medicaid managed care program can be organized to save the State enough dollars to be able to expand coverage to people who are not Medicaid-eligible, while at the same time ensuring access to quality care for all enrollees.

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

### **5.1.2 Summary of Evaluation Plan**

STC # 68 requires TennCare to file a draft Evaluation Plan by 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. TennCare reports on the findings associated with these Performance Measures in the CMS Annual Report filed pursuant to STC # 48.

## Section 5.2 Quality Assurance

### **5.2.1 MCO Quality Monitoring**

The Division of Quality Oversight is responsible for monitoring and ensuring that TennCare members 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.

TennCare has mandated that all Managed Care Organizations (MCOs) participating in the TennCare Project be accredited by the National Committee for Quality Assurance (NCQA). [Tennessee was the first State to require all of their 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 of TennCare, 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 will 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 TennCare and the NCQA. Analysis of data allows TennCare to assess MCO-specific performances and perform comparative analyses of TennCare to other Medicaid managed care plans throughout the country. These data are used to identify best practices and determine opportunities for improvement among the TennCare MCOs.

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 TennCare 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 TennCare.

### **5.2.2 Network Access**

Managed Care Organizations (MCOs) must assure 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.

### **5.2.3 External Quality Review Organization (EQRO) Activities**

TennCare 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 of TennCare 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*, *John B*, 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).

*Reference: See STC # 68 (Submission of a Draft Evaluation Plan).*

### **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 TennCare 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. Annually, 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 Grievance and Appeal Policies

### **5.3.1 Eligibility Appeals**

TennCare enrollees may appeal adverse actions affecting their TennCare eligibility. An “adverse action” is defined as a termination, suspension or reduction of TennCare eligibility. Individuals applying for TennCare may appeal denials of their applications for TennCare.

The Bureau of TennCare has delegated to the Department of Human Services (DHS) the authority to make eligibility-related determinations, including taking final administrative action in the context of eligibility-related appeals. The Division of Appeals and Hearings within DHS has the responsibility, using a single administrative process, for both TennCare Medicaid and TennCare Standard eligibility-related appeals. TennCare, 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, TennCare has implemented the following structure for eligibility-related appeals:

- When an enrollee’s eligibility for TennCare 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 TennCare 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 TennCare 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 TennCare 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 of TennCare 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.

TennCare 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 TennCare benefits. Generally, enrollees receive 10 days advance notice of a proposed adverse action affecting their TennCare 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 – not over matter of 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 TennCare 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.

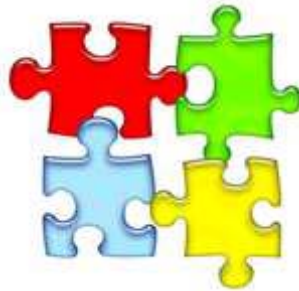
- The TennCare Solutions Unit (TSU) reviews each request for a hearing to determine if it comprises a valid factual dispute. If the enrollee's appeal fails to raise a valid factual dispute, TSU dismisses the request for a fair hearing. If TSU determines that the enrollee's appeal raises a factual dispute (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 TennCare'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. TennCare 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.*



# TENNCARE OPERATIONAL PROTOCOL

## **Chapter 6: Administration**



## Section 6.1 Administration and Management Systems

### **6.1.1 TCMIS Overview**

This chapter provides a description of the TennCare Management Information System (TCMIS), including a discussion of the system design and explanation of how the system interfaces with outside agencies and providers. In addition, this chapter will describe HIPAA compliance activities that have been completed and those scheduled to be completed during the course of the Demonstration.

The TCMIS is maintained and operated by an outside contractor, performing as the Facilities Manager. The 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.

### **6.1.2 Information System Modules**

The TCMIS is designed to meet the complex management and information needs of TennCare and has the capability to administer multiple benefits packages. This functionality is necessary to manage benefits service limits and optional benefit riders (i.e., optional dental benefits and pharmacy benefits). The TCMIS also automates many existing processes, such as imaging of letters generated to recipients and providers.

A description of the TCMIS major functions is provided below.

#### **6.1.2.1 Eligibility**

The TCMIS houses the master eligibility file for TennCare. 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 eligibility master 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), and
- Social Security Administration (SSA).

The eligibility subsystem 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 the 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, 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 subsystem 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 subsystem 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.

### **6.1.2.2 Encounter Data Processing**

The encounter data subsystem 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.

### **6.1.2.3 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 MR provider payments, Home and Community Based Services (HCBS) Waiver Providers, DCS, Commission on Aging, ICF/MR 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.

### **6.1.2.4 Provider Enrollment**

The provider enrollment subsystem 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 subsystem also tracks national provider identification numbers as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The subsystem 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.

### **6.1.2.5 Third Party Liability**

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

## **6.1.3 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.

### **6.1.3.1 Federal Reporting Requirements**

The federal reports listed below are produced from data stored in TCMIS and affiliated systems. A description of these reports can be found in section 6.4.

- 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)

#### **6.1.4 MCO Monitoring**

TCMIS assists several Bureau of TennCare 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.

#### **6.1.5 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 EPSDT monitoring activities to ensure compliance with federal EPSDT requirements.

TCMIS includes an EPSDT 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.

#### **6.1.6 HIPAA 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). TennCare 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, maintenance of, and adherence to, privacy and security policies that address the permitted use and disclosure of PHI 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 also requires that TennCare 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 6.2 Budget Neutrality

The Bureau of TennCare is responsible for assuring that major expenditures remain within the federal financial participation (FFP) cap. The Bureau of TennCare's Health Informatics and Fiscal Services Divisions have primary responsibility for monitoring TennCare 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 # 61 (Limit on Title XIX Funding).*

Individuals who are eligible for TennCare and whose expenditures are funded at Title XIX matching rates are one of three types: (1) those who are currently eligible under Tennessee's existing Medicaid State Plan; (2) those who could be eligible for Medicaid if Tennessee amended its State Plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 425.217; and (3) those who could not be eligible without Section 1115 authority. Tennessee will be 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 who could not be eligible without section 1115 authority (as defined by group 3 above).

*Reference: See STCs # 62 (Risk) & # 63 (Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement).*

Each yearly ceiling for TennCare will be the sum of two budget components: (A) the projected cost of services rendered to specified Medicaid Eligibility Groups (MEGs); and (B) 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 will be excluded from the budget neutrality formula except as explained elsewhere.

*Reference: See STC # 64a (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 # 64(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 8 – 11**

<b>Eligibility Group</b>	<b>Trend</b>	<b>DY 8 (SFY 2010)</b>	<b>DY 9 (SFY 2011)</b>	<b>DY 10 (SFY 2012)</b>	<b>DY 11 (SFY 2013)</b>
EG1 Disabled**	5.82%	\$1,253.79	\$1,326.76	\$1,403.98	\$1,485.69
EG2 Over 65***	5.01%	\$843.92	\$886.20	\$930.60	\$977.22
EG3 Children	6.24%	\$377.82	\$401.40	\$426.45	\$453.06
EG4 Adults	6.05%	\$733.56	\$777.94	\$825.01	\$874.92
EG5 Duals	5.54%	\$531.03	\$560.45	\$591.50	\$624.27
EG8 Med Exp Child*	6.24%	\$377.82	\$401.40	\$426.45	\$453.06

\*Optional Targeted Low Income Children funded using Title XIX

\*\*Includes EG-9 H – Disabled

\*\*\*Includes EG-10 H – Over 65

Source: STC # 64c

*Reference: See STC # 64c (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 11, and represents the maximum amount of FFP that the State may receive for Title XIX expenditures during the Demonstration period, as described in STC # 53(g). The budget neutrality expenditure limit is equal to (1) the sum of all subcomponents described in STC # 64(a)(1) for all DYs, times the Composite Federal Share described in STC # 64(f), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in STC # 64(d).

*Reference: See STC # 64e (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 (State Fiscal Year) 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 # 64d (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 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 # 65 (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**

<b>DY</b>	<b>Cumulative Target Definition</b>	<b>Percentage</b>
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 8	Cumulative budget neutrality cap plus:	0 percent

*Reference: See STC # 66 (Enforcement of Budget Neutrality).*

## Section 6.3 Federal Financial Participation

To receive the federal reimbursement to which states are entitled under Title XIX, TennCare shall submit quarterly reports (CMS-37 and CMS-64) to CMS as described below. These reports shall be the vehicle by which TennCare provides regular accounting of all administrative and service expenditures allowed under the waivers approved for the operation of TennCare.

*Reference: Section X General Financial Requirements (STCs 52 – 60).*

## Section 6.4 Financial Reporting

### **6.4.1 Medicaid Program Budget Report -- CMS-37**

**Responsibility:** Financial Operations  
**Frequency:** Quarterly

The CMS-37 is a quarterly financial report submitted by TennCare that provides a statement of TennCare'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), TennCare 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 # 56 (Standard Funding Process).*

### **6.4.2 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. TennCare reports on this form all administrative and service expenditures approved for the operation of TennCare. 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 # 52 (Quarterly Expenditure Reports) and # 53 (Reporting Expenditures in the Demonstration).*

### **6.4.3 Actual Certified Public Expenditures (CPEs)**

**Responsibility:** Financial Operations  
**Frequency:** Annually (fiscal year basis), within 12 months of the end of the year

TennCare 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 # 57h (Extent of Federal Financial Participation for the Demonstration) & STC Attachment F (Certified Public Expenditures Protocol).*

#### **6.4.4 Person-Specific Eligibility and Paid Claims Data – CMS-2082**

**Responsibility:** Information Systems  
**Frequency:** Quarterly

TennCare submits person-specific eligibility and paid claims data to CMS electronically on a quarterly basis. Five files are included in the quarterly submission: eligibility data; inpatient claims; long term institutional care claims; prescription drug claims; and all other claims.

#### **6.4.5 Annual Report on Home and Community Based Services Waivers – CMS-372 and/or CMS-372(s)**

**Responsibility:** Long Term Care Unit  
**Frequency:** Annually, within 18 months after the close of the waiver year

TennCare submits a separate CMS-372/CMS-372(s) for each of its Home and Community Based Services (HCBS) Waiver Programs: the Arlington Home and Community Based Services Waiver for the Mentally Retarded; the Statewide Home and Community Based Services Waiver for the Mentally Retarded; and the Self-Determination Waiver for the Mentally Retarded. These reports are used by CMS to compare the actual number of services and expenditures incurred under the waivers with the original estimates.



# TENNCARE OPERATIONAL PROTOCOL

## **Chapter 7: Program Integrity**



## Section 7.1 Program Integrity

### **7.1.1 Philosophy of TennCare Program Integrity**

The Bureau of TennCare has a strong commitment to program integrity (PI). TennCare protects PI and the well-being of 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 “declare[d] it to be public policy of the State of Tennessee that TennCare fraud and abuse [will] be identified and dealt with aggressively and appropriately.”<sup>19</sup>

### **7.1.2 Discussion of PI**

The TennCare Division of Audit and Program Integrity (A&PI) is the entity at TennCare with primary responsibility for ensuring TennCare’s program integrity, although many TennCare offices and divisions have a role to play in PI. There are two offices within the Division of Audit and Program Integrity: the Office of Program Integrity (OPI) and the Office of Audit (OA).

OPI performs the following key functions:

- Fraud analytics
- Surveillance and utilization review/fraud and abuse subsystems oversight
- Coordination and oversight of PI activities
- Provider Fraud Task Force (PFTF) database

The key functions of OA include:

- Annual Bureau risk assessment analysis
- Compliance with Section 6032 of the DRA
- Audits/reviews and investigations
- Sub-recipient monitoring
- Provider investigations
- Coordination of Payment Error Rate Measurement (PERM)
- Electronic Health Record Incentive Program (EHR-IP)

Although the scope of TennCare’s PI activities is extensive, it is important to note that there are other State agencies outside of TennCare that also play important roles in ensuring TennCare

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<sup>19</sup> Preamble to the “TennCare Fraud and Abuse Reform Act,” T.C.A. § 71-5-2502.

PI – for example, the Office of the Attorney General (OAG) and the Medicaid Fraud Control Unit (MFCU).

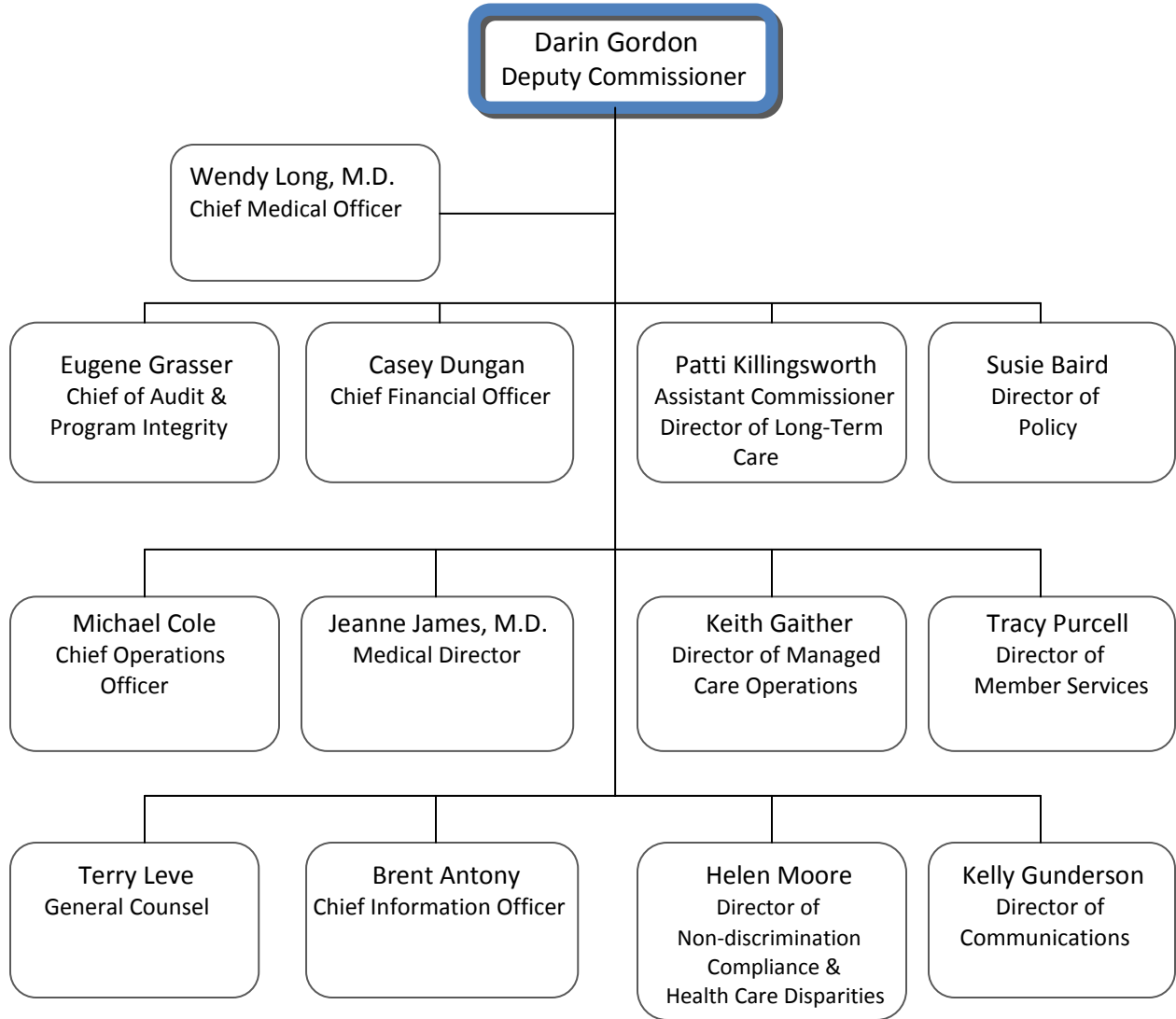
### **7.1.3 Summary of PI**

Various operational duties are carried out under TennCare's PI program. These include:

- Finding and Investigating Medicaid Fraud and Abuse
- Operations Related to Enrollees and Utilization of Services (e.g., enrollment reviews, enrollee verifications)
- Operations Related to Payments (e.g., pre-payment and post-payment reviews)
- Operations Related to Provider Screening and Enrollment (e.g., provider credentialing policies and procedures, record retention)
- Operations Related to Disclosures
- Education about the False Claims Act

# 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) <sup>20</sup>	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) <sup>21</sup>	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 where the contract exists solely between the individual and the insurance company	A medical care program of the Indian Health Services (IHS) or a tribal organization
Any of the above types of policies where: 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.	Benefits received through the Veteran's Administration
	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.

<sup>20</sup> AccessTN stopped accepting new applications on October 15, 2010. Enrollment reopened on December 2, 2010, but premium assistance remains closed at this time.

<sup>21</sup> 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.

<b>Types of Policies that Count as "Insurance"</b>	<b>Types of Policies that Do Not Count as "Insurance"</b>
<p>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> <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"> <li>The policy contains fewer benefits than TennCare;</li> <li>The policy costs more than TennCare; or</li> <li>The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.</li> </ul>	

*TennCare Medicaid Rule 1200-13-13-.01; TennCare Standard Rule 1200-13-14-.01*

## 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
  - Arthrogyrosis 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
  - 
  - 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 (East, Middle, & West)**

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

**AMERIGROUP (Middle)**

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

**Volunteer State Health Plan**

**(BlueCare – East & West and TennCare Select - Statewide)**

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

**Dental Benefits Manager (DBM)**

**Delta Dental (“TennDent”)**

P.O. Box 281078 Nashville, TN 37228-1078  
(615) 255-3175

**Pharmacy Benefits Manager (PBM)**

**SXC Health Solutions Corporation**

2441 Warrenville Road Suite 610  
Lisle, IL. 60532-3642  
(630) 577-3100

## 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 (the request for a change must meet all 6 of the following criteria):**

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.*

### **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 # 41(Plan Enrollment and Disenrollment).*

**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.

Routine MCO hardship 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 # 41 (Plan Enrollment and Disenrollment).*

**Examples of routine MCO changes allowed under TennCare rules include:**

1. MCO change requested within 45 calendar days (inclusive of mail time) of the date of the letter that provides notification of health plan assignment.
2. MCO change requested because all immediate family members were not assigned to the same plan, other than those assigned to TennCare Select.
3. When an enrollee changes place of residence, thus moving out of a plan's service area.
4. When an administrative error has occurred in assigning an enrollee to a plan not serving their Grand Division.

## **Attachment F**

### **Helpful Telephone Numbers**

**Family Assistance Service Center**

1-866-311-4287 ((615) 743-2000 in the Nashville area)  
Spanish Assistance Line 1-866-311-4290

**TennCare TTY Information Line for persons with speech & hearing impairments**

1-800-779-3101

**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 ((615) 507-6000 in the Nashville area)

**TennCare Fraud and Abuse Line**

1-800-433-3982

FAX (615) 256-3852

E-mail address: [TennCare.Fraud@tn.gov](mailto:TennCare.Fraud@tn.gov)

## **Attachment G**

### **Terms and Conditions for Access**

#### **Non-Specialty Care**

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 or 30 minutes
- Distance/Time Urban: 20 miles or 30 minutes
- 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 minutes, 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 Care Services:**

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 minutes, 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.

**Lab and X-Ray Services:**

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access 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: TennCare/Middle Tennessee CRA Attachment III General Access Standards & TennCare/East & West Tennessee CRA Attachment III General Access Standards*

## Specialty 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 served to ensure that the number of non-dual members per provider does not exceed the following:

<b>Maximum Number of Non-Dual Members per Provider by Specialty</b>	
<b>Specialty</b>	<b>Number of Non-Dual Members</b>

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: TennCare/Middle Tennessee CRA Attachment IV Specialty Network Standards & TennCare/East & West Tennessee CRA Attachment IV Specialty Network Standards*

### Access & Availability for Behavioral Health Services

Following are the 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, the Bureau evaluates the MCO's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

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

<b>Service Type</b>	<b>Geographic Access Requirements</b>	<b>Maximum Time for Admission/Appointment</b>
Psychiatric Inpatient Hospital Service	Travel distance does not exceed 60 miles for at least 75% of members and 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	<p>Travel distance does not exceed 75 miles for at least 75% of <b>ADULT</b> members and does not exceed 150 miles for at least 90% of <b>ADULT</b> members</p> <hr/> <p>Travel distance does not exceed 60 miles for at least 75% of <b>CHILD</b> members and does not exceed 90 miles for at least 90% of <b>CHILD</b> members</p>	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 60 miles for at least 75% of members and 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 60 miles for at least 75% of members and 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

<b>Service Type</b>	<b>Geographic Access Requirements</b>	<b>Maximum Time for Admission/Appointment</b>
24-Hour Residential Treatment Services (Substance Abuse)	Travel distance does not exceed 75 miles for at least 75% of members and does not exceed 120 miles for at least 90% of 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	Travel distance does not exceed 60 miles for at least 75% of <b>ADULT</b> members and does not exceed 90 miles for at least 90% of <b>ADULT</b> members	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

When the above standards are not met, an acceptable Corrective Action Plan (CAP) will be requested by the Bureau which details the MCO's intended course of action to resolve any deficiency (ies) identified. The Bureau will evaluate the CAP and, at its own discretion, determine network adequacy, considering any alternative measures and documentation of unique market conditions.

*Reference: TennCare/Middle Tennessee CRA Attachment V Access & Availability for Behavioral Health Services & TennCare/East & West Tennessee CRA Attachment V Access & Availability for Behavioral Health Services*

## Attachment H

### Table of Contents of TennCare II Waiver Special Terms and Conditions (STCs)

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Demonstration Approval Period: July 1, 2010 – June 30, 2013

Amendments #9 & # 10 Period: July 1, 2010 – June 30, 2013

Amendment #11 Period: December 16, 2010 – June 30, 2013

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