



Division of
**Health Care
Finance & Administration**

TennCare

TMA Insurance Workshops
October 2015

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**Please Hold All Questions until the End of
the Presentation**

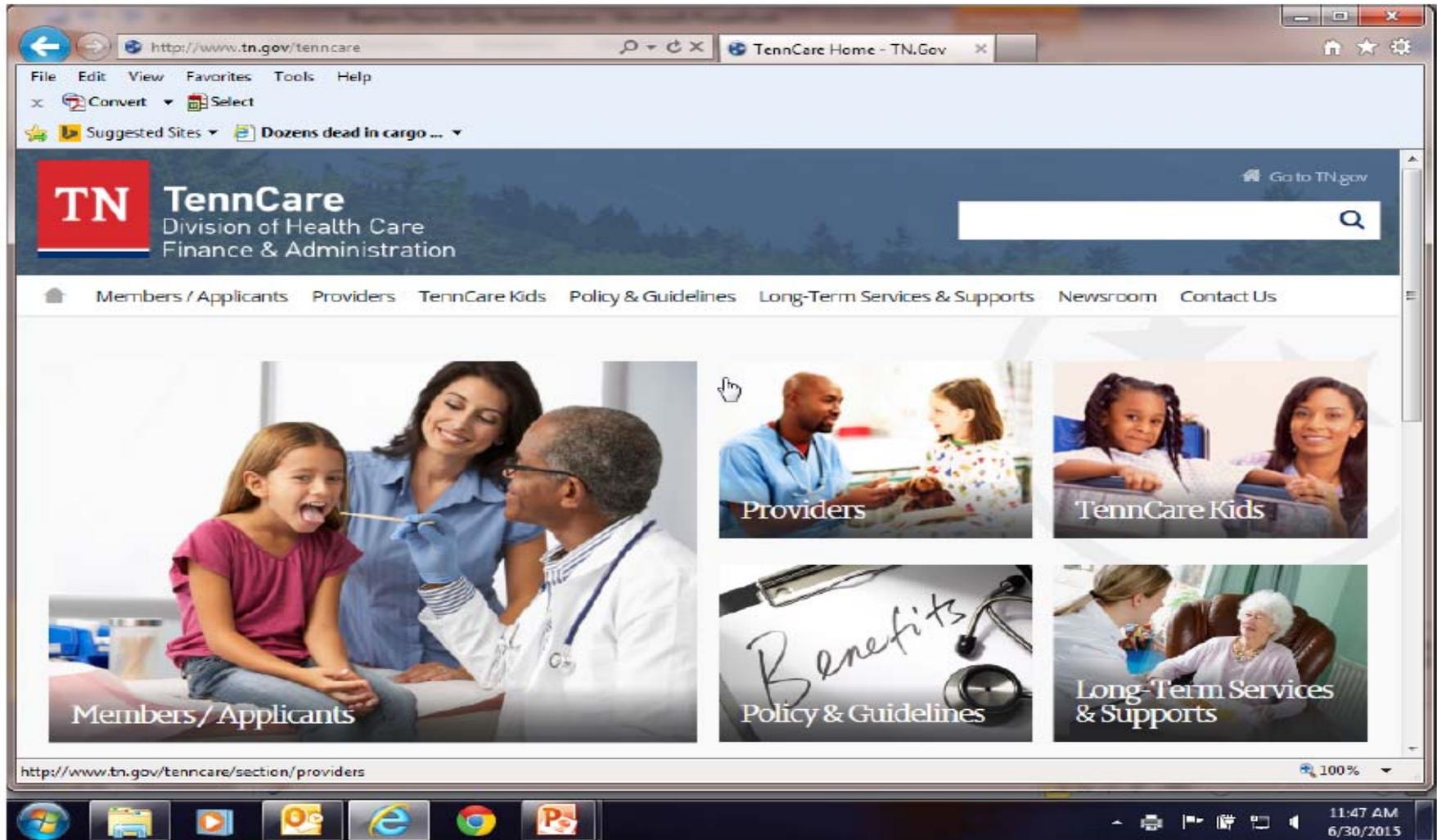
2015 Summer/Fall Topics

- New Website and TN State Government Logos
- TennCare Enrollment
- Budget Reductions/Updates
- PCP Rate Bump Audit
- Incarcerated TennCare Enrollees
- Online Medicaid Provider Registration
- Episodes of Care
- Provider Reminders

TN.gov Website Redesign

- New design went live on 6/22/2015.
- Simplified and streamlined navigation.
- Consistent look across departments for easier identification of and access to state services.
- Embedded search engines for full site as well as for each department.
- Help button at the bottom of every page.

New TennCare Website



Coexisting with the State Seal & Tristar



Tennessee Was a House of Brands



After: Branded House



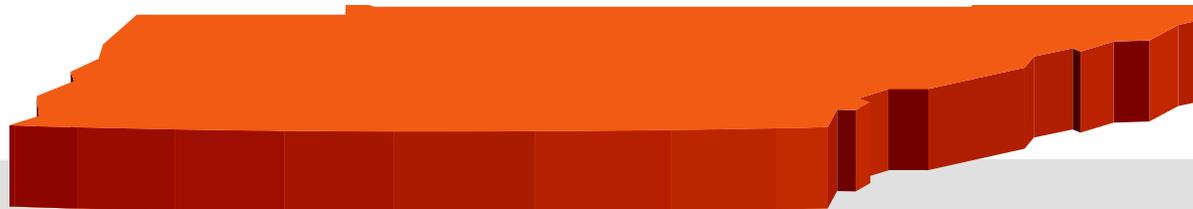


TennCare Snapshot

- TennCare's primary goal is to deliver high quality, cost effective care.
- TennCare covers more than 1.4 million Tennesseans.
- TennCare has an annual budget of \$10.3 billion.

Statewide MCOs

- Effective January 1, 2015
- TennCare MCCs no longer contracted by Grand Region.
- 3 “Statewide” MCOs:
 - Amerigroup
 - BlueCare
 - UnitedHealthcare Community Plan



Total TennCare Enrollment as of 9/1/2015

- Total Enrollment - **1,444,812**
- East TN Enrollment
 - 487,817
- Middle TN Enrollment
 - 485,776
- West TN Enrollment
 - 407,927
- TennCare Select (state-wide) Enrollment
 - 63,292

Enrollment by Region as of 9/1/2015

- East TN
 - UHC Community Plan 168,820
 - BlueCare 194,496
 - Amerigroup 124,501
- Middle TN
 - UHC Community Plan 164,679
 - BlueCare 157,535
 - AmeriGroup 163,562
- West TN
 - UHC Community Plan 139,601
 - BlueCare 148,898
 - Amerigroup 119,428



Budget Reductions/Impacts for July 1, 2015

- Provider Fee Reductions Bought Back SFY 2016
 - 1% reduction bought back with one time appropriations for SFY 2015 and 2016
 - Next SFY 2017 the reduction will be full 2% unless additional appropriations are funded

Budget Reductions/Impacts (cont'd.)

- 340B Pricing
 - Section 2.12.9.60 of the MCO Contractor Risk Agreement (CRA) requires the MCO to specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing.
 - This requirement was bought back with one time appropriations and will not be enforced for SFY 2015 or SFY 2016

Budget Reductions/Impacts (cont'd.)

- Therapy Code Reimbursement
 - The following codes to be reimbursed at the lesser of 1) MCOs current reimbursement amount, or 2) the current published CMS reimbursement amount:

92508	97002	97026	97116
92521	97004	97028	97124
92522	97012	97032	97140
92523	97016	97033	97150
92524	97018	97034	97530
92597	97022	97035	97750
92607	97024	97112	97761
			G0283

Budget Reductions/Impacts (cont'd.)

- E&M / Therapy Same Day
 - Will not pay a provider for an Evaluation and Management code on the same date of service for which Physical Therapy Services or Speech Therapy Services are paid to that same provider.

Budget Reductions/Impacts (cont'd.)

- Assay Drug Testing Limit for Adults
 - Effective 10/1/2015 - limit frequency to two (2) services per year for the following services:

G6056 Assay of Opiates
G6053 Assay of Amphetamines
83992 Assay of Phencyclidine
G6044 Assay of Cocaine
G6046 Assay of Dihydromorphinone
G6043 Assay of Barbiturates
G6045 Assay of Dihydrocodeinone
83835 Assay of Metanephrines
G6041 Assay of Alkaloids

*MCO policies should prohibit use of 8xxxx codes where CMS has provided a G code

Pharmacy Related Reductions

- Compounded Prescriptions – effective 7/1/2015
 - Will require prior authorization to ensure all compounded prescriptions are medically necessary.
 - Will be approved only when the indication, therapeutic amount, and route of administration of each of the active ingredients are FDA approved or CMS recognized compendia supported.
 - Further details available on the Pharmacy Benefit Managers (PBM) website
<https://tenncare.magellanhealth.com>

Pharmacy Related Reductions (cont'd.)

- Buprenorphine-containing-medications for Opioid Addiction – effective 10/1/2015
 - Benefit limit for enrollees being treated with buprenorphine-containing-medications for Office-based Opioid Addiction.
 - Lifetime limit of two (2) years supply of buprenorphine-containing addiction-treatment medications.
 - Further details will be available on the PBMs website after September 1, 2015.

PCP Rate Bump - Audit

- In accordance with Section 1202 of the Affordable Care Act, qualified Medicaid primary care providers practicing in family medicine, general internal medicine, pediatric medicine and related subspecialties who meet specified requirements are eligible to receive enhanced reimbursement rates.
- This applies to dates of service on and after January 1, 2013, through December 31, 2014.

PCP Rate Bump – Audit (cont'd.)

- As indicated in the final ruling, States are required to conduct an annual audit to review providers who received the higher payments to verify that they are either appropriately Board certified or that 60 % of their paid claims during that period were for the identified E&M and vaccine administration codes.
- TennCare has conducted an audit for each eligible calendar year (CY 2013 and CY 2014) of the providers who completed the attestation form and indicated on the form that they qualified based on 60 % of their total Medicaid/TennCare paid claims volume.

PCP Rate Bump – Audit (cont'd.)

- Each provider attesting under the 60% rule signed a form which stated:
 - *“I further understand that if it is later determined I did not qualify for payment under this provision, then Medicaid will recoup the difference between the Medicare rate and the Medicaid rate associated with dates of service that I was not qualified.”.*

PCP Rate Bump – Audit (cont'd.)

- If a provider did not qualify for the rate bump, they will receive a letter from the MCO notifying them they did not meet the minimum qualification of 60 percent of total Medicaid/TennCare paid claims volume for the identified E&M and vaccine administration codes in one or both eligible calendar years.

PCP Rate Bump – Audit (cont'd.)

- As a result of the audit, the MCO will be required to recoup the enhanced payments made to the provider.
- If a provider disagrees with the audit determination, he/she may ask for a reconsideration within 35 days from the date of the letter with appropriate supporting documentation.

Incarcerated TennCare Enrollees

- Tennessee Code Annotated 71-5-106(r)
 - Statute requires that TennCare suspend (rather than terminate) Medicaid eligibility for inmates of the Department of Corrections and local jails.
 - TennCare will now pay for inpatient claims for inmates in suspended status if:
 - the inmate receives such services in a non-correctional inpatient facility
 - The inmate remains at the facility as a patient for 24 hours or longer

Incarcerated TennCare Enrollees (cont'd.)

- Implementation of this new process began 4/1/2015.
- TennCare obtains census data from state and local penal facilities and now suspends Medicaid eligibility.
- TennCare reports an inmate's suspension status via TennCare Online Services and specifically notes such individuals are only eligible for limited inpatient services.

Incarcerated TennCare Enrollees (cont'd.)

User Information

Recipient ID:

11223344556

Recipient SSN:

Recipient Date of Birth:
(MM/DD/CCYY)

Submit

Reset

Verification # 1518257115

Recipient

Recipient ID
11223344556

Name
TENNCARE, TOMMY

Date of Birth
01/01/19xx

SSN
xxxxxxxx

Current MCO
TENNCARE SELECT

Current BHO
TENNCARE SELECT

Current DBM
No DBM on record

Eligibility - *Suspended Eligibility*

Benefit Plan:
Eligibility Category:
MCO:
Program:
Effective Date:
End Date:
Copay?:

Suspended Eligibility
TITLE 19 MEDICAID

TENNCARE SELECT
TennCare Medicaid
05/22/2015

TN

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Medicaid Provider Registration

- All TennCare Medicaid provider registration is now electronic.
- Thousands of providers have either registered or re-validated through the online Provider Registration System to date.

Medicaid Provider Registration (cont'd.)

- In the coming months, all providers currently enrolled as a TN Medicaid provider, will receive a re-validation letter asking them to register/re-validate through the online electronic process.
- Failure to re-validate through TennCare's online system **will** result in the termination of a provider's TN Medicaid ID Number.

Consequences of not re-validating?

- Termination of your TN Medicaid provider number will also terminate any contracts you currently hold with any of the MCOs (Amerigroup, BlueCare, TennCare Select, UnitedHealthcare Community Plan).
- Without an active TN Medicaid provider number you will not be eligible for any payments from TennCare/Medicaid crossover claims or any of its contractors (MCOs, DBM, PBM).

Consequences of not re-validating? (cont'd.)

- Without an active TN Medicaid provider number you will not be able to enter into any Single Case Agreements with an MCO or be paid as an out-of-network provider even with an out-of-network authorization from the MCO.
- Without an active TN Medicaid provider number you will not be able to access the TennCare Online Services web portal used by providers to verify TennCare enrollee eligibility.

Consequences of not re-validating? (cont'd.)

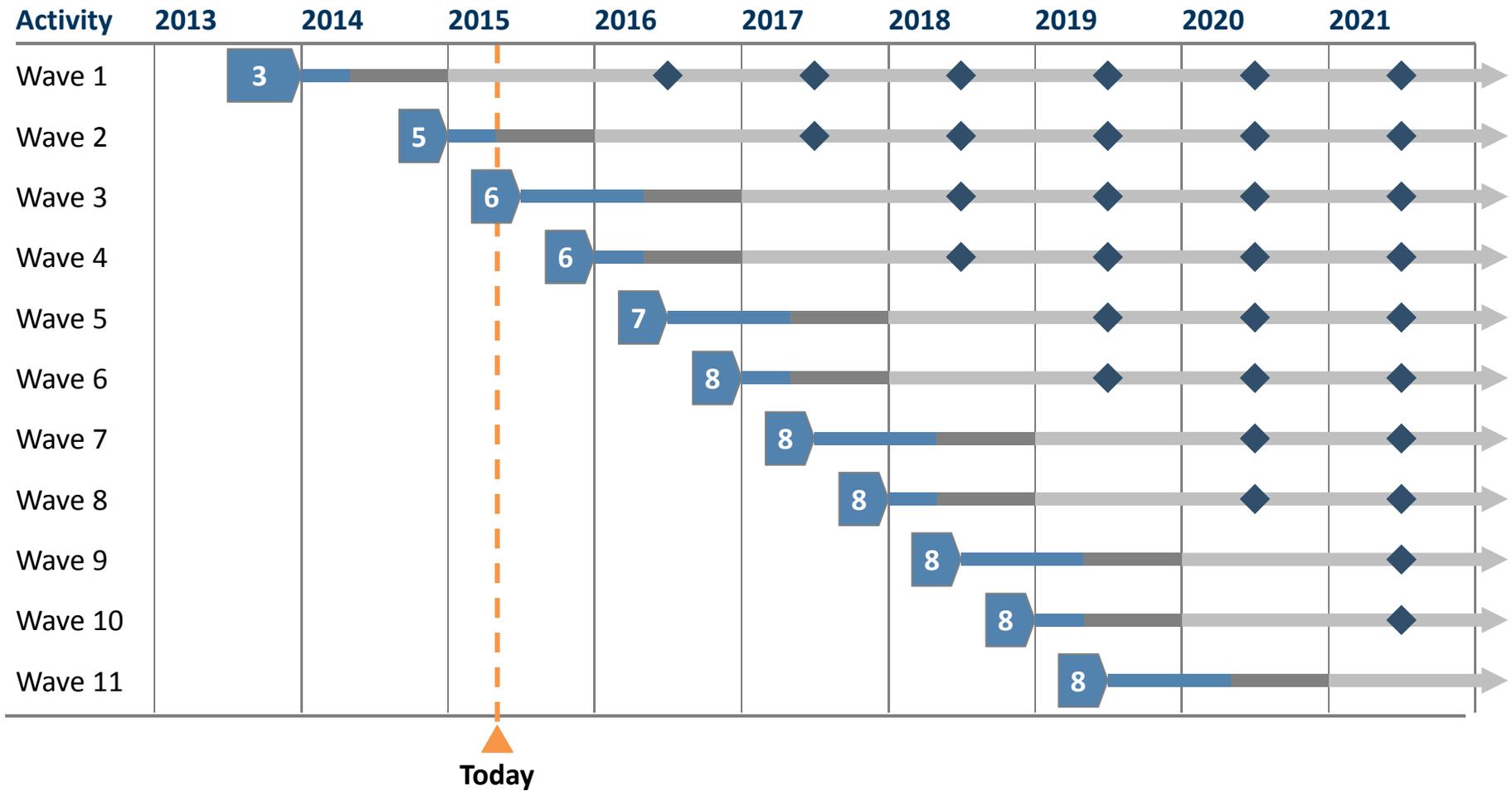
- Without an active TN Medicaid Provider Number, any medications you prescribe for a TennCare enrollee cannot be filled by a pharmacy.

Access the TennCare Provider Registration webpage here:
<http://www.tn.gov/tenncare/topic/provider-registration>



Where We Are Today With Episodes of Care

- # Localization & # of new episodes
- Payer implementation period
- Reporting period
- Performance period
- ◆ Payments released



Episodes of Care: 75 in 5 years

- Wave 1
 - Perinatal
 - Asthma acute exacerbation
 - Total joint replacement
- Wave 2
 - Colonoscopy
 - COPD acute exacerbation
 - Cholecystectomy
 - PCI
- Wave 3
 - EGD
 - Respiratory Infection
 - Simple pneumonia
 - UTI (inpatient)
 - GI hemorrhage
 - UTI (outpatient)
- Wave 4
 - ADHD (multiple)
 - CHF acute exacerbation
 - ODD
 - CABG
 - Cardiac valve

Episodes of Care: 75 in 5 years (cont'd.)

- Wave 5

- Breast cancer (multiple)
- Tonsillectomy
- Otitis
- Anxiety
- PTSD
- Breast biopsy

- Wave 6

- Cellulitis & other bacterial skin infection
- Neonatal Part II (multiple)
- Neonatal Part I (multiple)
- HIV
- Hepatitis C
- Bronchiolitis & RSV pneumonia

Episodes of Care: 75 in 5 years (cont'd.)

- Wave 7

- Other medical non-infectious orthopedic
- Schizophrenia (multiple)
- Diabetes acute exacerbation
- Spinal fusion exc. cervical
- Lumbar laminectomy
- Hip/Pelvic fracture
- Knee arthroscopy

- Wave 8

- Hemophilia & other coagulation disorders
- Anal procedures exc colon resection
- Colon cancer
- Coronary artery disease & angina
- Hernia procedures
- Cardiac arrhythmia
- Sickle cell
- Pacemaker/Defibrillator

Episodes of Care: 75 in 5 years (cont'd.)

- Wave 9

- Mild/Moderate depression
- Major depression
- Lung cancer (multiple)
- Female reproductive cancer
- Other major bowel
- Bariatric surgery

- Wave 10

- Fluid electrolyte imbalance
- Renal failure
- Hepatobiliary & pancreatic cancer
- Pancreatitis
- GERD acute exacerbation
- Drug dependence
- GI obstruction
- Rheumatoid arthritis

Episodes of Care: 75 in 5 years (cont'd.)

- Wave 11
 - Bipolar (multiple)
 - Conduct disorder
 - Epileptic seizure
 - Hypotension/Syncope
 - Kidney & urinary tract stones
 - Other respiratory infection
 - Dermatitis/Urticaria
- For more information on TN Payment Reform and Strategic Planning & Innovation

<http://www.tn.gov/hcfa/section/strategic-planning-and-innovation-group>

EHR Incentive Payments as of 9/1/2015

- Eligible Professionals
 - Year 1 Payments = \$84,915,031
 - Year 2 Payments = \$12,234,363
 - Year 3 Payments = \$ 5,828,184
 - Year 4 Payments = \$ 1,368,506
- Eligible Hospitals
 - Year 1 Payments = \$69,501,887
 - Year 2 Payments = \$36,821,163
 - Year 3 Payments = \$10,991,125

EHR Incentive Payments (cont'd.)

- What's Coming 2015
 - CMS has proposed a rule change which will allow **ALL** providers to attest to MU for a 90-day period for 2015.
 - Providers will have to have a 2014 Edition CEHRT in order to attest.
 - More details will be provided when CMS finalizes its rule.

EHR Incentive Payments (cont'd.)

- What's Coming 2016
 - 2016 is the **last year** that providers can enroll and begin receiving EHR Incentive Payments.
 - Providers who BEGIN participation in the incentive program during 2016 will not be able to skip years but will have to attest every year through 2021.

EHR Incentive Payments – Contacting Us

- For the quickest answers about MU general information, ***including questions about why your attestation was returned***, and these MU pages:
 - MU Core Set Questions
 - MU Menu Set Questions
 - MU Clinical Quality Measures (CQMs)
- Send your email to:
 - EHRMeaningfuluse.TennCare@tn.gov

EHR - Contacting Us (cont'd.)

- General EHR information and questions about these pages:
 - Provider Questions
 - EHR Questions
 - Required Forms
 - Patient Volume
- Send your email to:
 - TennCare.EHRIncentive@tn.gov

* Medicaid Patient Encounter Volume is **always** a consecutive 90-day period in the **previous** calendar year.



Secondary Provider Data Requirement

Pursuant to Federal Regulation 42 CFR 455.410(b):

“the State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers”.

2ndary Provider Data Requirements (cont'd.)

- Effective 9/25/15 TennCare will deny claims containing secondary provider data (rendering, attending, referring, ordering, operating, etc.) for any provider who is not actively enrolled with the TennCare program.
- The submission of an NPI for the secondary provider is required, unless the provider has an atypical provider status.

Crossover Claims – Top Denial Reason Codes

Code - Reason for Denial

- 814 - Crossover-Possible Conflict of Another Claim
- 5014 - Exact Duplicate of Previously Paid Claim (1500)
- 5007 - Exact Duplicate of Previously Paid Claim (UB04)
- 260 - Recipient Eligible in the SLMB Program
- 230 - No Crossover Coinsurance/Deductible Due
- 536 - Insurance EOB Does Not Match Claim-Resubmit

DSNP Medicare Advantage Plan Crossover Claims

- DSNP Medicare Advantage Plans that claims automatically crossover to the State:
 - Amerigroup
 - Healthspring
 - UnitedHealthcare
 - Volunteer State Health Plan (BCBS)
 - Wellcare
- DSNP Medicare Advantage Plans that claims do not automatically crossover to the State:
 - Humana

Medicare Advantage EOBs

- The following data elements must be on the EOB:
 - Dates of Service
 - Procedure codes and modifiers
 - Co-pay
 - Coinsurance
 - Deductible
 - Billed Amount
 - Allowed Amount
 - Paid Amount
 - Provider Name
 - Paid Provider NPI
 - Patient Name

Top Reasons Claims are Returned to Providers

- Another health benefit plan (box 11d) if yes box 9, 9a and 9d must be completed
- NPI Number Invalid or Missing (box 33a)
- Did not submit copy of EOMB
- Paid date on EOMB Missing or Illegible
- Dates of service on claim must match dates of service on EOMB
- Charges on claim must match EOMB

Member MCO Change Period

- TennCare enrollee may change MCOs 1 time within the initial 45 calendar days from enrollment into the program.
- Enrollee shall remain in designated MCO until given opportunity to change during the *Annual Change Period*.
- Change Period for West TN - month of *March*.
- Change Period for Middle TN - month of *May*.
- Change Period for East TN - month of *July*.

Hardship Criteria Change Requests

Must meet all of the following six (6) hardship criteria:

1. The member has a medical condition that requires complex, extensive, and ongoing care:
2. The member's PCP/Specialist has stopped participating in the member's current MCO and refused continuation of care to the member in his current MCO assignment; and

Hardship Criteria Change Requests (cont'd.)

3. The ongoing medical condition is such that another Provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and
4. The current MCO has been unable to negotiate continued care with the current PCP/Specialist; and

Hardship Criteria Change Requests (cont'd.)

5. The current Provider of services is in the network of one or more alternative MCOs; and
6. An alternative MCO is available to enrolled members.

* Last year, less than 5% of all hardship criteria change requests were made because they met all 6 criteria.

Not Considered Hardship

- Enrollee is unhappy with the current MCO or PCP, but there is no hardship medical situation.
- Enrollee claims lack of access to services but the Plan meets the state's access standards.
- Enrollee is unhappy with current PCP or Providers, and has refused alternative PCP or Provider choices offered by the MCO.

Not Considered Hardship (cont'd.)

- Enrollee is concerned that a current Provider might drop out of the Plan in the future.
- Enrollee is a Medicare beneficiary who (with exception of pharmacy) may utilize choice of Providers, regardless of network affiliation.

TENNderCare renamed - TennCare Kids

- As you probably know, TENNderCare is TennCare's EPSDT program for members up to age of 21.
- As of 6/22/2015 TENNderCare changed its name to:

TennCare Kids

* Please be aware of this change and update any references your organization may have to TENNderCare with the new **TennCare Kids** name and/or logo.

TennCare Provider Services

1-800-852-2683

**[http://www.tn.gov/tenncare/section/
providers](http://www.tn.gov/tenncare/section/providers)**

Questions?

