



Bureau of TennCare

2011

TennCare is Tennessee's Managed-Care Medicaid Program serving approximately 1.2 million culturally and racially diversified low-income children, pregnant women and disabled Tennesseans, with an annual budget of approximately \$8.9 billion.



2011 Summer/Fall Topics:

- TennCare Enrollment
- New Benefits/Rate Reductions
- Medicaid Electronic Health Record Incentive Program
- Medicare “Cross-Over” Claims
- Automated Clearing House (ACH)
- MCO Open Change Period/Hardships
- Provider Reminders
- Health Care Reform



What is TennCare?

- Bureau of TennCare
 - Tennessee's Single State **Medicaid** Agency charged with the administration of the TennCare program
- Tennessee's Medicaid Program
 - Uses managed care to cover persons otherwise not eligible for Medicaid
 - Oldest Medicaid managed care program in the country



What is TennCare? (cont.)

- TennCare services are offered through managed care entities
- Medical and behavioral services covered by “At-Risk” Managed Care Organizations (MCOs) in each region of the state
 - TennCare Select covers certain special populations
- Prescription drugs covered by a statewide Pharmacy Benefits Manager
- Dental Services for children under the age of 21 covered by a statewide Dental Benefits Manager



Grand Regions by MCO



<i>West Tennessee</i>	
AmeriChoice	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, Weakley
BlueCare	
TennCare Select	
<i>Middle Tennessee</i>	
AmeriChoice	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
AmeriGroup	
TennCare Select	
<i>East Tennessee</i>	
AmeriChoice	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
BlueCare	
TennCare Select	



TennCare Enrollment

[As of May 31, 2011]

- Total Enrollment - 1,218,307
- East TN Enrollment
 - 418,550
- Middle TN Enrollment
 - 401,608
- West TN Enrollment
 - 353,368
- TennCare Select (State-wide) Enrollment
 - 44,781



MCC Enrollment

- East TN
 - AmeriChoice 189,440
 - BlueCare 229,110
- Middle TN
 - AmeriChoice 201,002
 - AmeriGroup 200,606
- West TN
 - AmeriChoice 170,000
 - BlueCare 183,368



Benefit Changes/Reductions **effective 7/1/2011**

- Elimination of grant to TNAAP
- Reduction in grant monies to Meharry, the MED, Metro Nashville General and Jellico hospitals
- Limit on sleeping pills for adults
- Limit on Suboxone pills for adults
- Elimination of acne/rosacea products for adults
- TennCare payment limit of \$4 on widely accessible \$4 generic drugs
- Better purchasing agreements related to factor for Hemophilia



Benefit Changes/Reductions (cont.)

- Births paid at blended rate – vaginal rates plus 17%
- ER physicians paid triage fee only for treatment of non-emergent cases
- Coverage of new smoking cessation benefit for adults



Rate Reductions

- 4.25% rate reduction effective 7/1/2011 for:
 - Nursing homes, transportation, dental, and home health providers
 - Lab and X-ray services
 - MCO admin rates
 - PACE Program
- Rate reduction of 4.25% in place 7/1/2011 through 12/31/2011



Rate Reductions (cont.)

- Effective 1/1/2012 rate reduction will increase to 8.5%
- However, possibility that states will be credited for error made by SSA known as SDW
- If SDW monies credited to TN by 1/1/2012, rate reduction will remain 4.25% for rest of fiscal year (until 6/30/2012)
- If SDW funds not received by 1/1/2012, a \$2 co-pay for adult non-emergency transportation will also be implemented in addition to the 8.5% rate reduction



Medicaid Electronic Health Record Incentive Program for Eligible Professionals

- ARRA established funding for States to provide incentive payments to eligible Medicaid providers to adopt, implement and upgrade certified EHR systems.
- Eligible professionals with 30% Medicaid volume** can receive up to \$63,750 over six years.

(\$21,250 = Year 1, \$8,500 = Years 2-6)

<http://www.tn.gov/tenncare/hitech.html>



MEDICARE “Cross-Over” Claims

- Claims for dual eligible
(Traditional Medicare/Medicaid)
members “cross-over” automatically
- Claims for dual eligible
(Medicare Advantage/Medicaid)
members must be filed on paper directly
to TennCare at:
P.O. Box 460
Nashville, TN 37202



Crossover Claims Top Denial Reasons

4127/4205 - Cannot Prioritize Recipient's Programs

Occurs when: the patient has more than one open eligibility type (SNF, ICF, or any type HCBS etc.) along with XIX or QMB. The system cannot determine which eligibility is the primary payer. Therefore, all cross over claims will remain in a Suspended Status and recycle every 100 days. If the claim denies and the patient is crossover eligible and there is a hard copy claim on file a Provider Inquiry will turn in the claim for reprocessing. Electronic claims must be dropped to paper and resubmitted.

How to avoid Provider Inquiry can not assist with this type of eligibility. The Long Term Care Unit determines, approves and enters this type of eligibility. LTC must close all segments (ICF, PAE's etc.) with an end date that reflects the last LTC or HCBS Date of Service in order for cross over claims to pay.

814 - Crossover-Possible Conflict of Another Claim

Occurs when: the same D.O.S is billed by a different provider for the same procedure code.

How to avoid: at this time this is an automatic system denial. The provider must resubmit a claim w/ the Medicare RA. In some cases a coversheet is needed as a form of appeal so that it can be visually reviewed for override.



Crossover Claims Top Denial Reasons (cont.)

1092 - Billing Provider Tax ID Does Not Match Claim

Occurs when: the tax ID on claim does not match what is on file.

How to avoid: contact Provider Inquiry to see what Tax Id information Provider Enrollment has on file for the group or sole proprietor. If you wish to change our system to correlate with Medicare go online to our website @ download an application (Mark X Tax ID # Change). Provider Enrollment will update the files to correlate with Medicare.

230 - No Crossover Coinsurance/Deductible Due

Occurs when: there is no financial responsibility for the recipient.

How to avoid: if there is a co-pay, coinsurance or deductible due after Medicare has processed the claim, the Medicare EOMB page reflecting the information needs to be sent with the claim. If the member has an HMO or Medicare Advantage plan you will need to submit the EOMB showing the monies due for co-pay, coinsurance and deductible. If after Medicare, HMO or Advantage plan has processed your claim there is no monies due, then you have received the proper denial. If you determine that your claim has been processed incorrectly then you may contact Provider Inquiry for a review.



Crossover Claims Top Denial Reasons (cont.)

362 - Medicare Deductible Greater Than Maximum

Occurs when: Medicaid is billed deductible amounts for a patient for a particular year that total more than the deductible that was set by Medicare. This most often occurs when the patient changes to a Medicare HMO during the year. The HMO does not coordinate benefits on the deductible so their system begins the patients deductible over again. The total deductible can not be charged repeatedly in one year for the patient. This denial can also occur if a previously paid claim has not been voided by **both Medicare and Medicaid.**

How to avoid: there is not any way to avoid this but, it can be resolved by having the patient contact the plan they were originally on and getting a letter that states how much of the deductible was met for them in the year that covers your date of service. Then you will refile your claim with the current Medicare plan for correct payment and forward to the corrected information to Tennessee Medicaid. If the previous paid claim has not been voided by **both Medicare and Medicaid** then we ***can not*** duplicate a reimbursement.



Crossover Claims Top Denial Reasons (cont.)

536 – Insurance EOB Does Not Match Claim-Resubmit

Occurs when: the EOMB does not match the claim form. The common factors include: D.O.S, Provider NPI number, charges, and procedure codes etc. This denial also frequently occurs when the primary EOB is not a Medicare plan, instead the patient does not have Medicare and the EOB is from a private insurance or TennCare MCO (BlueCare, TC Select, AmeriChoice or AmeriGroup). In this case TennCare Medicaid is the primary and claims are billed and paid by the MCO.

How to avoid: before mailing your claims to the Tennessee Medicaid Crossover addresses, verify that this patient is crossover eligible and the EOB is a Medicare, HMO or Advantage Plan. If both statements are true, verify that the EOB is for D.O.S, Provider NPI number, procedure codes and charge amounts you are billing on the claim form are accurate in comparison. Also, the NPI # located on the remit should be billing provider listed on the claim form in order for the claim to be paid to the correct provider.



Medicare Advantage EOBs must include the following to be processed:

1. Dates of Service
2. Procedure codes and modifiers
3. Co-pay
4. Coinsurance
5. Deductible
6. Billed Amount
7. Allowed Amount
8. Paid Amount
9. Provider Name
10. Provider NPI
11. Patient Name



Reasons claims have to be Returned to Providers (RTP'd)

1. NPI Number Invalid (box 33A)
2. NPI Number Missing (box 6)
3. Paid date on EOMB Missing or Illegible
4. Did not submit copy of EOMB
5. Dates of service on claim must match dates of service on EOMB
6. Charges on claim must match EOMB



Medicare Advantage Automatic Cross-over

- Target date 1/1/2012 – testing and potential implementation of automatic electronic claim “cross-over” of dual eligible members with Medicare Advantage/Medicaid



Interested In Being Paid Electronically?

- Automated Clearing House or “ACH”
- “ACH” stands for Automated Clearing House. Sometimes this is also referred to as “EFT” (Electronic Funds Transfer) or simply as Direct Deposit. All three terms are used interchangeably.

** This should not to be confused with a “wire transfer.”*



Benefits of ACH

- The ACH system will:
 - Increase the speed of receiving your payment
 - Decrease the chance of a lost or stolen check
 - Make payment easier through automation
 - Link you with all state departments for payment



How to Enroll in ACH

- ACH Forms are available at:
<http://www.tn.gov/tenncare/pro-ach.html>
- Send completed ACH Forms to:

Bureau of TennCare
Division of Finance, 4 East
310 Great Circle Road
Nashville, TN 37243

or

FAX: (615) 532-3479
Attention: April Carter



Member MCO Change Period

Pursuant to TennCare Rules 1200-13-13.03(1)(a)2.:

- A TennCare enrollee may change MCOs one (1) time within the initial forty-five (45) calendar days from date of letter informing them of their MCO assignment.
- Enrollee shall remain in designated plan (MCO) until given opportunity to change during Annual Change Period.
- Annual Change Period for West TN - month of March.
- Annual Change Period for Middle TN - month of May.
- Annual Change Period for East TN – month of July.

* *Only way an enrollee may request change of MCO outside the designated annual change period is through a medical “hardship criteria” appeal.*



Not Considered Hardship

The following situations will not be determined to be “hardships”:

1. The enrollee is unhappy with the current MCO or PCP, but there is no hardship medical situation;
2. The enrollee claims lack of access to services but the Plan meets the State’s access standard;
3. The enrollee is unhappy with current PCP or Providers, and has refused alternative PCP or Provider choices offered by the MCO;
4. The enrollee is concerned that a current Provider might drop out of the Plan in the future;
5. The enrollee is a Medicare beneficiary who (with the exception of pharmacy) may utilize choice of Providers, regardless of network affiliation.



Hardship Criteria Change Requests

Requests for hardship MCO reassignment must meet all the following six (6) hardship criteria (determinations made on individual basis):

1. The member has a medical condition that requires complex, extensive, and ongoing care; and
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
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
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.



MCO Change Request Percentages

- Only 1.5% (18,000) of the approximately 1.2 million total enrollees made an MCO Change Request from 7/1/2010 thru 6/30/2011
 - 31% of requests came from East Region
 - 45% of requests came from Middle Region
 - 24% of requests came from West Region
- < 5% were granted an MCO Change because they met medical hardship criteria



Updated TennCare Policies

- Full complete policies can be found on the TennCare Website:
<http://www.tn.gov/tenncare/pol-policies.html>
- PRO 08-001- When a Provider May Bill a TennCare Enrollee – updated 5/31/2011
 - Applies to providers who have a TN Medicaid Provider ID Number regardless of contract status with MCOs
- CON 09-001 – Third Party Liability – updated 6/9/2011
 - Provides guidelines and timeframe on MCO claim recoupment



Appeal Posters

- Contractual Requirement
 - Require that the provider display notices of enrollee's right to appeal adverse action affecting services in public areas of their facility(s)
 - The Contractor (MCC) shall ensure that the providers have the correct and adequate supply of public notices.
- Yellow Appeal Poster must be displayed in a conspicuous location (i.e. – waiting room, check in window, check out window)



Provider Inquiries/Escalating Issues

1. Contact “Provider Services” at the MCC
2. Contact your assigned MCC Provider Representative
3. Escalate the complaint to a MCC Manager in the Provider Relations Department
4. TennCare Provider Service Department by phoning 1-800-852-2683, and telling them you need to file a MCC complaint
5. Independent Review through Tennessee Department of Commerce & Insurance at

www.tn.gov/commerce/tenncare



REPORTING FRAUD & ABUSE

Office of Inspector General

1-800-433-3982

FAX: 615-256-3852

<http://www.tn.gov/tnoig/>

Tips can be anonymous

Cash for Tips Policy

http://www.tn.gov/tnoig/Documents/IncentiveProgram_OIG.pdf

- Tip cannot be anonymous
- Can claim cash reward if your tip leads to prosecution
- Details of how program works available at the link above
- Posters available at TennCare help desk



5010 Conversion

- Beginning on January 1, 2012, a federal mandate requires health plans, clearinghouses, and providers to use new standards in electronically conducting certain health care administrative transactions at the heart of daily operations, including claims, remittance, eligibility, and claims status requests and responses.
- Upgrading from the current HIPAA 4010A1 transaction standards to the new 5010 standards addresses several key goals:
 - Increase transaction uniformity
 - Support pay for performance
 - Streamline reimbursement transactions



5010 Conversion (cont.)

Two key factors prompted the upgrade to 5010:

- the government and industry's shared goal of providing higher quality, lower cost health care, and
- the need for a comprehensive electronic data exchange environment for the vastly expanded ICD-10-CM and PCS code set transition mandated for compliance by October 1, 2013.



ICD-10 Coming Soon

- International Classification of Diseases, 10th Revision
- ICD-10-CM and ICD-10-PCS which replaces the currently used ICD-9 codes is set to be implemented by October 1, 2013



Provider Communications

E-Mail subscription:

Sign up at:

<http://tn.gov/tenncare/pro-emailsubcrip.html>



RSS Feed:

Sign up at:

<http://tn.gov/tenncare/providers.html>



TENNCARE PROVIDER SERVICES

1-800-852-2683



National Health Care Reform

- On March 23, 2010, President Obama signed Patient Protection and Affordable Care Act into law. This new law will provide more health insurance options for Tennesseans and require most individuals to carry some type of health insurance.
- The law changes many aspects of health care in the United States. This includes:
 - Required insurance coverage for almost all individuals
 - Financial help for some to buy health insurance
 - New rules for insurance providers
 - The creation of a health insurance exchange
 - Broad changes to Medicaid (TennCare) and CHIP (CoverKids) programs



National Health Care Reform (Cont.)

- While the law provides a detailed framework of the changes ahead, the federal government must release policies, regulations and guidelines before final details are known. This website houses the current available information and will be updated when new details are released along with resources and tools to help understand the changes ahead.
- National Health Care Reform information can be found on the TN.gov website at <http://www.tn.gov/nationalhealthreform>



THANK YOU
for your continued service to some of
Tennessee's most vulnerable citizens.