



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 government to provide certain defined benefits to persons meeting certain 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 aged 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 use of a managed care program 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 five-year Section 1115(a) waiver that began on July 1, 2002. On October 5, 2007, CMS approved a three-year extension of TennCare II through June 30, 2010. An application has been submitted to CMS to continue TennCare II for a three-year period beyond June 30, 2010.

TennCare is in the process of adding an important new component called the CHOICES program. This program is being 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 would allow eligible individuals to remain in their homes and communities rather than having to enter nursing facilities. Implementation of CHOICES will begin in Middle Tennessee in March 2010. Implementation of CHOICES in East and West Tennessee will occur following the Middle Tennessee start-up. Once CHOICES is implemented statewide, eligible TennCare enrollees will receive long-term care services, nursing facility and/or home and community-based services through the CHOICES program.

<p>Section 1.2 Purpose of the Operational Protocol</p>
--

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.state.tn.us/tenncare/quick-redirect.html?url=http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS028494&intNumPerPage=10#>

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.state.tn.us/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: for TennCare Medicaid: <http://tennessee.gov/sos/rules/1200/1200-13/1200-13.htm>; for TennCare Standard, go to: <http://www.tennessee.gov/sos/rules/1200/1200-13/1200-13-14.pdf>
- Court cases affecting TennCare. These may be viewed at the following site: <http://www.state.tn.us/tenncare/legal.html>
- TennCare policies, which are prepared by the Bureau of TennCare and posted on the TennCare website. These may be viewed at the following site: <http://www.state.tn.us/tenncare/pol-policies.html>

The TennCare website, <http://www.state.tn.us/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
- Financial Operations
- Information Systems
- Policy
- Office of General Counsel
- Long-Term Care
- Public Affairs
- Internal Audit
- 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, together with their specific TennCare functions, are shown in Table 1-1.

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

Agency	Functions
Office of the Comptroller	<ul style="list-style-type: none"> • Performance of TennCare audits • Performance of Managed Care Organizations (MCO) audits

Agency	Functions
	<ul style="list-style-type: none"> • Performance of quarterly audits of the implementation of the <i>Grier</i> Consent Decree • Establishment of rates for Nursing Facilities and for Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR)
Department of Children's Services	<ul style="list-style-type: none"> • Determination of Medicaid eligibility for children coming into state custody • Provision of residential treatment and targeted case management services for TennCare-eligible children in state custody • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) outreach
Department of Commerce and Insurance	<ul style="list-style-type: none"> • Licensure and financial oversight of Health Maintenance Organizations/ Managed Care Organizations (HMOs/MCOs), and Third Party Administrators/Dental Benefit Managers (DBMs) • Administration of the TennCare Claims Processing Panel and independent Review Process for review of denied claims submitted by providers • Establishment and enforcement of uniform claim form instruction standards • Administration of annual MCO network adequacy study required by <i>T.C.A. 56-32-231</i> • Operational oversight of HMOs, and TPA/DBMs, 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, TPA operational subcontractors
Department of Education	<ul style="list-style-type: none"> • EPSDT outreach
Department of Health	<ul style="list-style-type: none"> • EPSDT outreach • EPSDT screenings • Provision of dental screenings and services to children • Presumptive eligibility determinations for pregnant women • Presumptive eligibility determinations for uninsured women needing treatment for breast and/or cervical cancer • Enrollee education and advocacy
Department of Human Services	<ul style="list-style-type: none"> • TennCare eligibility determinations • Provision of education and assistance regarding the

Agency	Functions
	TennCare eligibility process <ul style="list-style-type: none"> • Family assistance information line • Appeals of eligibility-related issues • EPSDT outreach
Department of Mental Health and Developmental Disabilities	<ul style="list-style-type: none"> • Consultation on the behavioral health component of the TennCare demonstration waiver, obtaining attestations from psychiatric residential facilities on compliance with CMS standards on the use of seclusion and restraint; and identifying TennCare members who belong to the Priority Population (CTG/TPG)

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**

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

TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering 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 one.

**Table 1-3
Types of Managed Care Entities**

Type of Entity	BBA Definition	Description of Services Provided	Reimbursement and Rate-Setting Methodology
Managed Care Organizations (MCOs)	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 (PHIP)	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 PHIP and providers; administrative fee, approved by CMS, paid to PHIP
Dental Benefits Manager (DBM) – non-risk	Prepaid Ambulatory Health Plan (PAHP)	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