



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 are now receiving both their physical health services and mental health and substance abuse services from their MCO. Upon implementation of CHOICES, TennCare enrollees will also be receiving long-term care services through their MCO network of providers. MCOs are required, by contract, to maintain adequate provider networks and meet provider access standards such as the following:

- Networks must include specified safety net providers for specified safety net services;
- Networks must include at least one Center of Excellence for people with HIV/AIDS in each of the Grand Divisions in which the MCO participates;
- Networks must include Centers of Excellence identified through the state's EPSDT program for treatment of children in state custody;
- Networks must include adequate numbers of physician specialists to meet the needs of the enrolled population;
- MCOs are encouraged to contract with Federally Qualified Health Centers (FQHCs). If an MCO chooses not to contract with FQHCs, it must demonstrate that its network is adequate without them to ensure needed capacity and range of services for vulnerable populations; and
- MCOs must contract with local health departments for EPSDT screenings, unless the individual MCO can demonstrate that it is able to meet the EPSDT screening goals without these providers.

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

4.1.2 TennCare Select

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

- Children who are eligible for Supplemental Security Income;
- 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 have to 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 the PCPs for behavioral health services.

Reference: See Rules 1200-13-13-.03(1) and 1200-13-14-.03(1) and STC # 40.

<p>Section 4.2 Organization of Managed Care Networks</p>
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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. MCOs are selected through the state's procurement process.

THREE GRAND DIVISIONS



WESTERN GRAND DIVISION

Benton
Carroll
Chester
Decatur
Dyer
Fayette
Gibson
Hardeman
Hardin
Haywood
Henderson
Henry
Lake
Lauderdale
Madison
McNairy
Obion
Shelby
Tipton
Weakley

MIDDLE GRAND DIVISION

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

EASTERN GRAND DIVISION

Anderson
Bledsoe
Bradley
Campbell
Carter
Claiborne
Cocke
Franklin
Hamblen
Hamilton
Grainger
Greene
Grundy
Jefferson
Johnson
Knox
Loudon
Marion
McMinn
Meigs
Monroe
Morgan
Polk
Rhea
Roane
Scott
Sequatchie
Sevier
Sullivan
Unicoi
Union
Washington

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 assure TennCare enrollees' timely access to health care. This Attachment addresses both primary care and care provided by specialists.

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 that person as a participant in the TennCare program within thirty calendar days of notification of enrollment into the MCO's plan or prior to the enrollee's 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 5% of calls not answered.

All MCOs are also required to report a full set of HEDIS data to the state annually. CAHPS and HEDIS performance indicators are compared to national norms and tracked over time in order 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), three H influenza type B (HiB), three hepatitis B, one chicken pox (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two 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) 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 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 Effectives 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 Advance 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 primary care providers. 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(a) and 1200-13-14-.03(a).

4.2.7 Best Practice Network (BPN)

The Best Practice Network (BPN) is composed of Best Practice Providers (BPP). 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% 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% 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%, with a benchmark of 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

<http://www.tn.gov/tenncare/forms/pay06002.pdf>

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

<http://www.tn.gov/tenncare/forms/pay08001.pdf>

<p>Section 4.3 Payment Mechanisms</p>

4.3.1 MCC Reimbursement Methodology

4.3.1.1 Managed Care Organizations (MCOs)

4.3.1.1.1 Full risk arrangements

All MCOs, other than TennCare Select, are reimbursed on a per-member/per-month (PMPM) capitation basis for the provision of both medical services and behavioral health and substance abuse services through their integrated services contract. The rates vary by age and eligibility category. Each MCO's contract provides for an additional capitation payment to be made for enrollees designated as SPMI/SED in the last 12 months.

Reference: For additional information about TennCare rates, see Policy Statement PAY 08-001 "Addressing Issues Affecting the Actuarial Soundness of TennCare Rates"

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, it receives administrative fees from the state to cover for 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 a part of the TennCare Select contract, include a Risk and Bonus component, placing 10% of the administrative fee at risk and providing a Bonus potential to earn 10% of the administrative fee for maintaining and/or meeting specified performance measures. The

performance measures and percentages of Risk and Bonus associated with each are listed below:

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

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.

Payments made pursuant to the Administrative category are made monthly 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

As specified in each MCO contract, MCOs reimburse Federally Qualified Health Centers (FQHCs) either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis. MCOs are also required, on at least an annual basis, to identify and report to the TennCare Bureau each FQHC with which the MCO contracts and the methodology under which the FQHC is reimbursed.

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 is received.

4.3.2.2 Methodology for Essential Access Hospital (EAH) payments

4.3.2.2.1 Eligible hospitals

Hospitals eligible to receive essential access hospital 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. The critical access hospitals 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 CFR 447.10.

Reference: See STC # 57e.

4.3.2.2.2 Allocation of the pool to segments of hospitals

The annual \$100 million 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 and Developmental Disabilities (TDMHDD) 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 critical access hospitals.

Reference: See STC # 57e.

4.3.2.2.3 Data

Calculation of the quarterly 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.

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 Managed Care Organization 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 Managed Care Organizations 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% or more of its total adjusted days covered by TennCare.

- OR -

A hospital may qualify if 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% of total adjusted days are covered by TennCare.

Reference: See STC # 57e.

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.

4.3.2.2.6 Calculation of amounts of 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. So, 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 values will be the amounts to be provided to the hospitals as an essential access hospital payment for the fiscal year.

Reference: See STC # 57e.

4.3.2.2.7 Payments

Hospitals are paid on a quarterly basis following the end of each quarter. 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, including the free-standing psychiatric hospitals, must be contracted providers with TennCare Select and, where available, at least one other Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents.

Reference: See STC # 57e.

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 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 section 1923(i) of the Social Security Act.

Reference: See STC # 57i.

4.3.3 Special Pool Payments to Critical Access Hospitals (CAH)

In accordance with the Special Terms and Conditions, the state shall make special pool payments to TennCare Critical Access Hospitals. (Payments for services received at CAHs by TennCare enrollees are made by the enrollee's respective MCC through the normal claims process.) The state's methodology for making these payments and for claiming federal financial participation for the payments is described below. The state must make these payments directly to the providers of the services as specified in 42 CFR 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 a managed care organization participating in TennCare.

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

- Payments are limited to specific legislative appropriations for which federal financial participation is available.
- In any state fiscal year where reimbursable TennCare costs incurred by CAHs exceed annual appropriations, the special pool payments are allocated equitably among the hospitals.
- Special pool payments to hospitals are made directly to the hospital by TennCare.

The CAH Supplemental Pool Payment process is as follows:

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 managed care organizations and any special payments to hospitals. Interim rates are calculated to reimburse hospitals at a rate that will not exceed 95% of TennCare reasonable costs. Inpatient Critical Access Hospital 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 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 for TennCare services made to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 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% of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospital.

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 Critical Access Hospital designation. At that time, interim rates will be established, and the designation will be confirmed with the Tennessee Department of Health.

Each CAH is required to maintain adequate financial and statistical records that are accurate and in sufficient detail 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.

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 the CMS staff. The state must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

Reference: See STC # 57g.

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 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 interfacing with the TennCare MMIS. 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% of claims within 60 days of receipt. The TennCare interface standard for data transfers is via FTP, using HIPAA transaction formats, with DVDs, CDs or 36-track compressed cartridges for backup contingency, initial file loads and TennCare selected communications.

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, and other medical services are required.

4.4.2.2 Format

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

Type of Claim	Required Format
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Professional	ASC X12N 837P
Institutional	ASC X12N 837I
Dental	ASC X12N 837D
Pharmacy	NCPDP 1.1

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 results in a HIPAA compliance edit results in the rejection of the entire file. All seven levels of HIPAA reporting compliance are validated. In the event that edits identified as threshold edits are greater than 2%, the entire file is also rejected. The MCC is usually given three 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.