



TennCare

TN Healthcare Symposium

2019

Sarah Tanksley Stockton, Communications Director

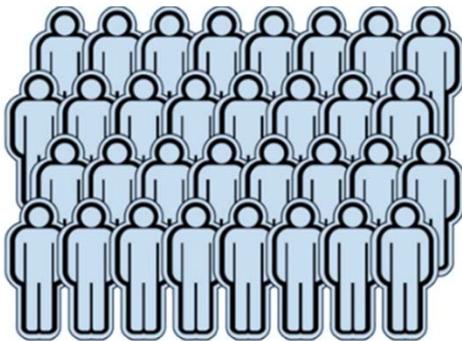


**Please Hold All Questions until End of
Presentation**

TennCare Snapshot

TennCare Mission: improving lives through high quality cost effective care.

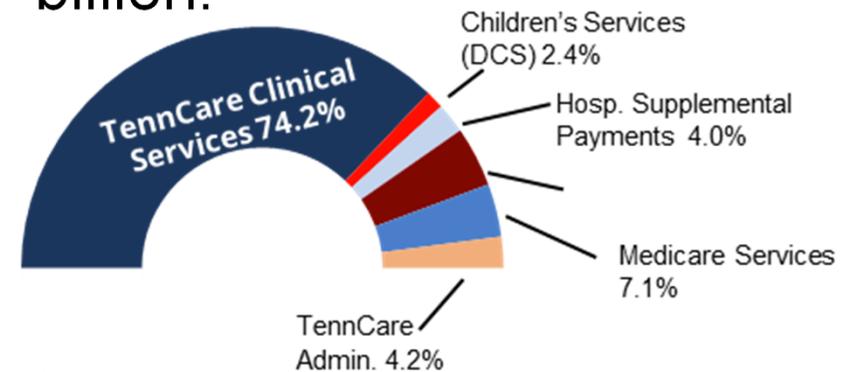
TennCare is Tennessee's Medicaid program which covers approximately 1.4* million low-income Tennesseans.



* Enrollment as of August 2019

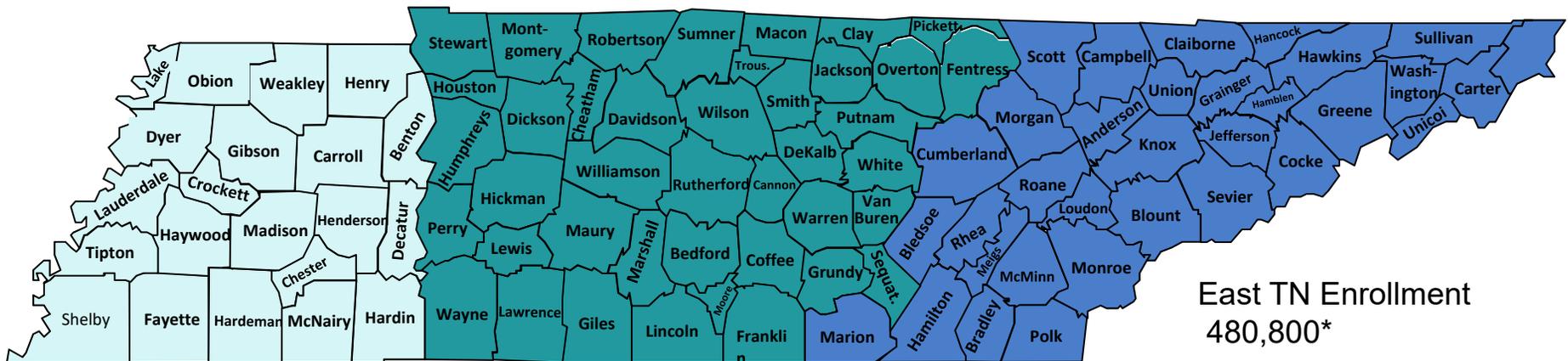
TennCare Vision: A healthier Tennessee.

The 2019 budget is approximately \$12 billion.



Statewide MCOs

- Three “Statewide” MCOs:
 - Amerigroup
 - BlueCare
 - UnitedHealthcare Community Plan



West TN Enrollment
386,770*

Middle TN Enrollment
482,315*

TennCare Select (statewide) Enrollment
68,870

* As of August 2019

Enrollment by Region as of August 2019

- East TN
 - UHC Community Plan 140,887
 - BlueCare 211,127
 - Amerigroup 128,786
- Middle TN
 - UHC Community Plan 161,558
 - BlueCare 162,305
 - AmeriGroup 158,452
- West TN
 - UHC Community Plan 120,314
 - BlueCare 148,708
 - Amerigroup 117,748

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Dental Benefits Manager (DBM)

- Effective 5/1/2019 – DentaQuest continues as the Dental Benefits Manager (DBM) providing comprehensive dental services as medically necessary for TennCare members (children).



DentaQuest Provider Service

- 888-291-3766
- www.dentaquest.com

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New Pharmacy Benefits Manager (PBM)

Effective 1/1/2020 – OptumRx will be the new Pharmacy Benefits Manager (PBM) for TennCare member pharmacy benefits.



TennCare Online Services (TCOS)

- As a reminder, TennCare moved the TCOS system to a state website.
- No longer a \$75 annual fee.
- Information on how to enroll in TCOS located at <https://www.tn.gov/tenncare/tenncare-online-services.html>

(Hand out on how to enroll in TCOS available at Help Desk)

Eligibility Redetermination Status in TCOS

There is a new section heading in the TCOS eligibility verification screen

Current Redetermination Status:

- **Renewal Packet Sent**  recipient has been mailed a packet and Date Field will display date it was mailed.
- **Received**  renewal packet was returned by recipient and Date Field will display date it was received.
- **Blank**  recipient not part of redetermination process or renewal packet has not been mailed to the recipient.

Eligibility Redetermination Status

01/01/2017

06/30/2017

[Submit](#)

[Reset](#)

Verification # 1718127262

Recipient

Recipient ID	Name	Date of Birth	SSN
111111111	SMITH , JANE	01/01/2000	123456789

Current MCO

BLUECARE

Current BHO

BLUECARE

Current DBM

DENTAQUEST USA INSURANCE CO INC

Current Redetermination Status

Current Redetermination Status:	Received
Date:	03/10/2017

Reporting Period PCP Name/Organization (PCP as of the end of the request period)

PHYSICIAN, IMA E

Reporting Period PCP NPI

1922006055

Email Address

Blank.Email@email.tn

Telephone Number

6155551212

Eligibility - Eligible for TennCare for Reporting Period

Benefit Plan:	Presumptive Eligibility
Eligibility Category:	
MCO:	BLUECARE
Program:	TennCare Medicaid
Effective Date:	01/01/2017
End Date:	06/30/2017
Copay?:	Yes

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Incarcerated TennCare Members

User Information

Recipient ID: <input type="text" value="11223344556"/>	Recipient SSN: <input type="text"/>	Recipient Date of Birth: (MM/DD/CCYY) <input type="text"/>
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Verification # 1518257115

Recipient

Recipient ID	Name	Date of Birth	SSN
11223344556	TENNCARE, TOMMY	01/01/19xx	xxxxxxx

Current MCO
TENNCARE SELECT

Current BHO
TENNCARE SELECT

Current DBM
No DBM on record

Eligibility - Suspended Eligibility

Benefit Plan:	Suspended Eligibility TITLE 19 MEDICAID
Eligibility Category:	
MCO:	TENNCARE SELECT
Program:	TennCare Medicaid
Effective Date:	05/22/2015
End Date:	
Copay?:	

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Top 6 Crossover Claim Denial Reason Codes

- 2019 – Recipients Eligible in the SLMB Program
 - **Occurs when:** This edit is posted when the only eligible program for the Recipient is SLMB, for the dates of service on the claim. The SLMB eligibility record exists only for later MARS reporting and not for medical benefits
 - **How to avoid:** Ensure Recipient is eligible for medical benefits (XIX/QMB/SSI) during dates of service
- 2021 – Recipient Not Eligible For Dates of Service-No Financial Benefits
 - **Occurs when:** If after the financial eligibility plans are merged together and the recipient is still not eligible, edit 2021 will post at the detail
 - **How to avoid:** Ensure Recipient is eligible during dates of service

Claim Denial Reason Codes

- 538 – Medicare Allowed Amount Missing
 - **Occurs when:** Total Medicare allowed amount missing
 - **How to avoid:** Billing amount-contractual obligation/withhold= allowed amount should always be on claims
- 1279 – Rendering Provider Not Eligible on All Dates of Service
 - **Occurs when:** a Rendering provider has been submitted with the qualifier of '82' and the Provider Enrollment Program effective and end date does not fall within all the claim's header dates of service
 - **How to avoid:** Rendering Providers has to be enrolled and have an active status an active Billing Medicaid number within all the claim's header DOS

Claim Denial Reason Codes

- 5014 – Exact Duplicate-Detail
 - **Occurs when:** A submitted CMS-1500 claim form has a detail line with the same recipient number, same provider number, same dates of service, same procedure, same modifiers as a detail line on a previously paid claim
 - **How to avoid:** Insure that the claim billed matches the attached EOMB. In cases where Medicare has paid the same billing NPI, but the rendering NPI is different from rendering NPI on the paid claim, a coversheet along with the remittance advice for both claims is needed as a form of appeal so that it can be visually reviewed for override

Claim Denial Reason Codes

- 1004 – Rendering Provider Not Eligible to Render Services on Dates of Service
 - **Occurs when:** the rendering provider assigned is not enrolled in either provider program Medicaid/Medicare or Medicare Xover Only during the entire detail dates of service of the claim for any of the following enrollment statuses: active, deceased, recertification date, license suspended/revoked, license not renewed, termed by CMS, termed by TennCare, legal action, duplicate enrollment record, number changed, change in ownership, termed by provider, retired, suspended by TennCare, undelivered mail, non-bill 12 months
 - **How to avoid:** Validate provider eligibility at time of service and prior to submission of claim

Provider Inquiries/Escalating Issues

1. Contact Provider Services at the MCC
2. Contact your assigned MCC Provider Relations Rep
3. Escalate the complaint to an MCC Manager in the Provider Relations Department
4. Call the TennCare Provider Services Line at 800-852-2683, option 3 to file a MCC complaint
5. File a Provider Complaint or Independent Review through TN Department of Commerce & Insurance (TDCI) at <https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution.html>

Provider Registration

Common Provider Registration Issues

- Groups must add all individual provider information to the group portal to ensure the individuals are linked properly.
- Review the provider type that was selected. Is this the same taxonomy being used to submit claims?
- If you are a provider type that is listed in the moderate/high risk levels – PECOS information must match.
- All individuals must enter the licenses effective date on their CAQH application.
- Once all entries are completed it is important to select “Submit to TennCare”
- If an issue is not resolved or a TennCare Medicaid ID is not received within 10 days please contact Provider.Registration@tn.gov.

Medicaid Provider Re-validation

- TennCare requires providers to re-validate with Medicaid every 3 years.
- Most providers “re-validate” each time they update their profile and select “submit to TennCare”.
- Access the TennCare Provider Registration webpage here: <http://www.tn.gov/tenncare/topic/provider-registration>

Medicaid Provider Re-validation

- All providers currently enrolled as a TN Medicaid provider, will receive an email (**supplied by the provider TennCare online registration portal**) asking them to 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.



Did you know? Termination of your TN Medicaid provider number will also terminate any contracts you currently hold with any of the MCOs.

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Consequences of not re-validating

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).
- 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.
- You will not be able to access the TennCare Online Services web portal used by providers to verify TennCare enrollee eligibility.
- Any medications you prescribe for a TennCare member cannot be filled by a pharmacy.

TennCare's Opioid Strategy

Primary Prevention

limit opioid exposure to prevent progression to chronic opioid use

- Implemented rule in January 2018 placing dosage and day coverage allowances on opioid prescriptions for naïve and acute users.
- Increased prior authorization requirements for all opioid refills.
- Continued support of nonpharmacological pain management and clinical services, such as physical therapy.

Secondary Prevention

early detection and intervention to reduce impact of opioid misuse

- Partnering with Tennessee Department of Health to better integrate the Controlled Substance Monitoring Database (CSMD).
- Developed MCO strategy to proactively engage women of childbearing age using opioids based on data and clinical risk.
 - The MCOs have performed over 20,000 outreaches to women of childbearing age in second quarter of 2018. This is an ongoing effort by all MCOs.

Tertiary Prevention

support active recovery for severe opioid dependence and addiction

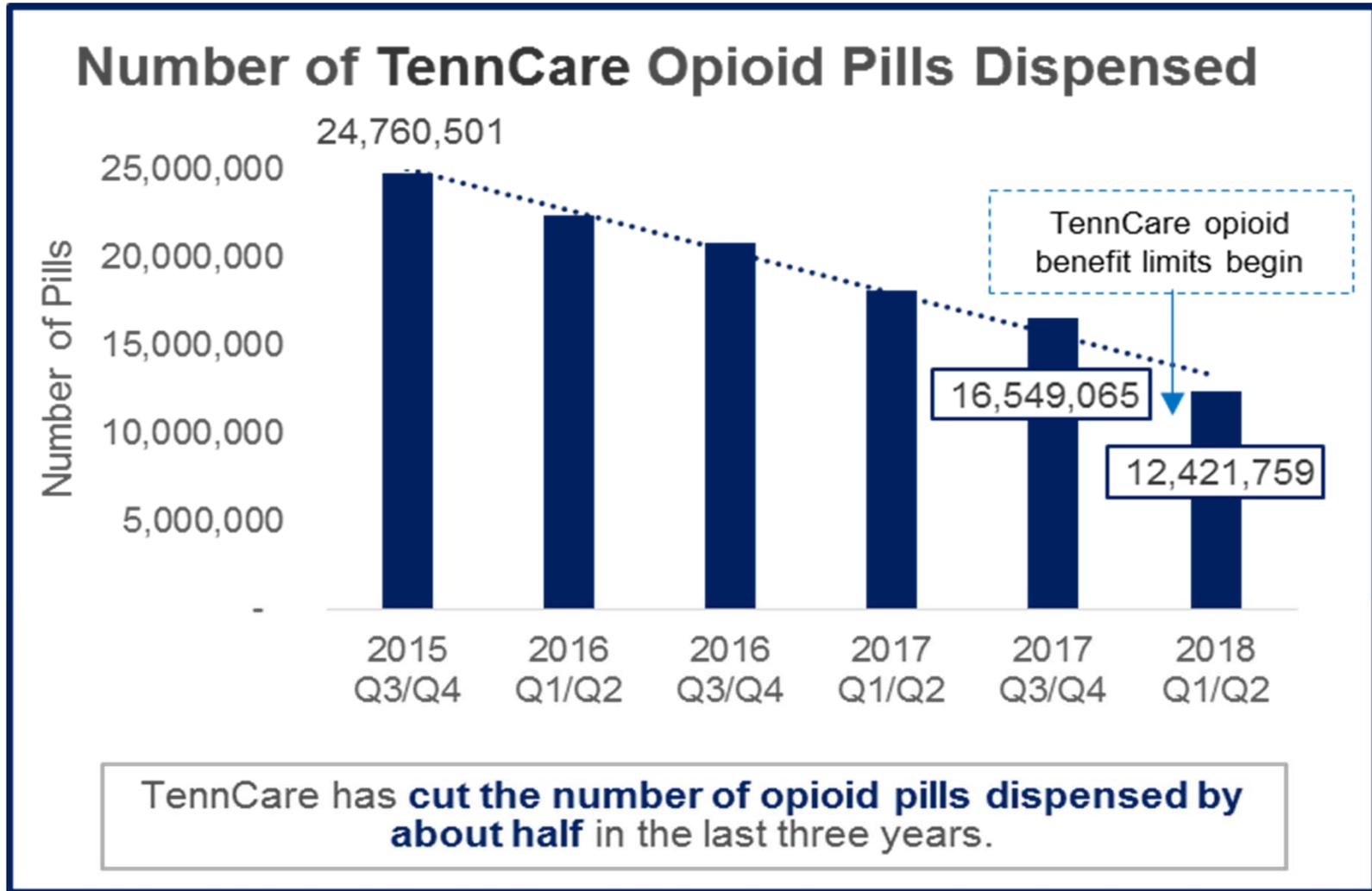
- Increased outreach to chronic opioid users to refer to treatment and prevent overdoses.
- The MCOs are actively building their networks of medication assisted treatment (MAT) provider to broaden access to high quality treatment for opioid and substance use disorder.
- Aligned chronic opioid user MME dosage allowances with CDC chronic pain guidelines.

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Combating the Opioid Epidemic

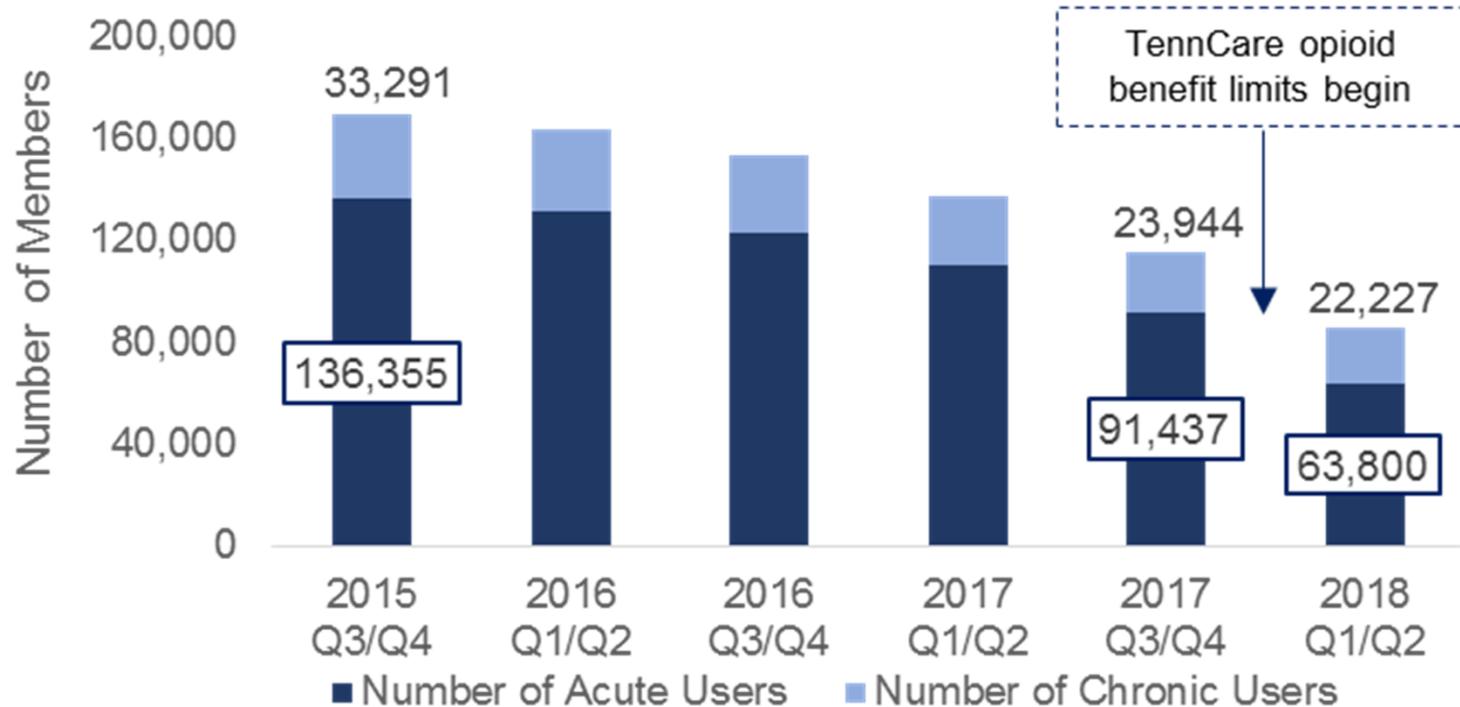


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Combating the Opioid Epidemic

Total Acute and Chronic TennCare Opioid Users



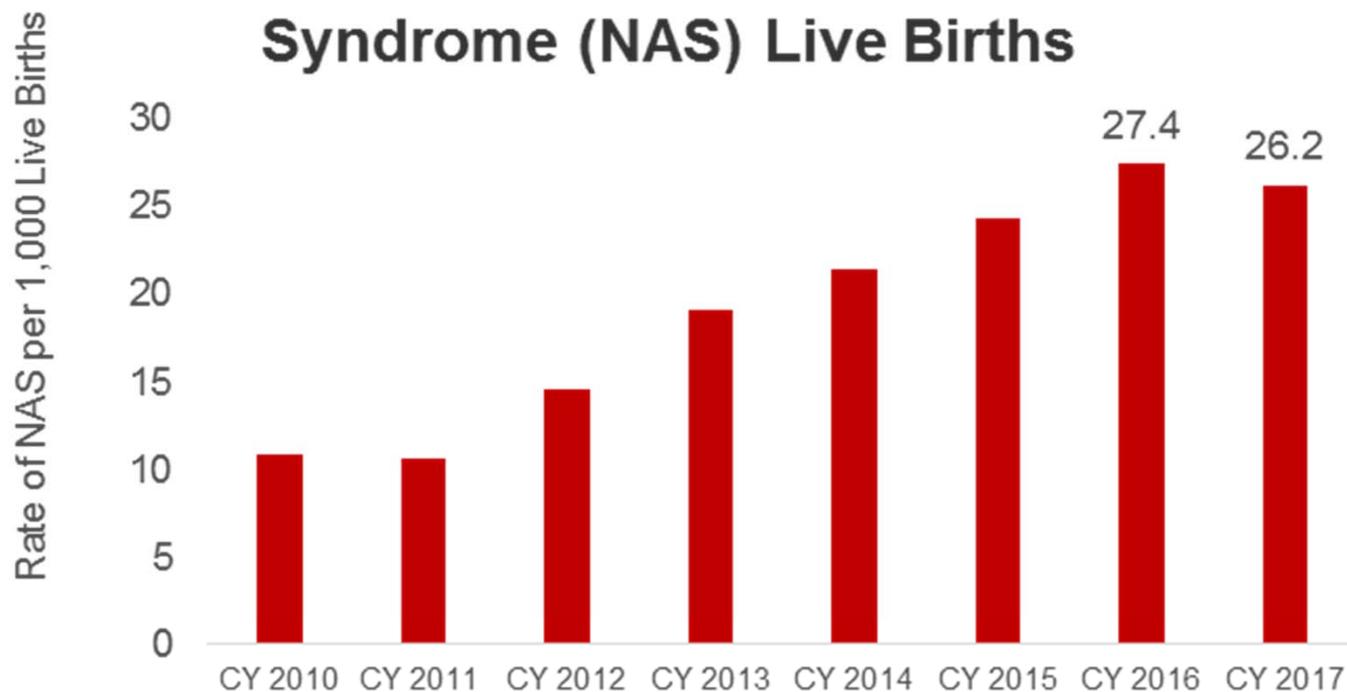
Overall, the number of TennCare **new, acute opioid users** has declined by about **53%** since 2015.

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Combating the Opioid Epidemic

TennCare Neonatal Abstinence Syndrome (NAS) Live Births



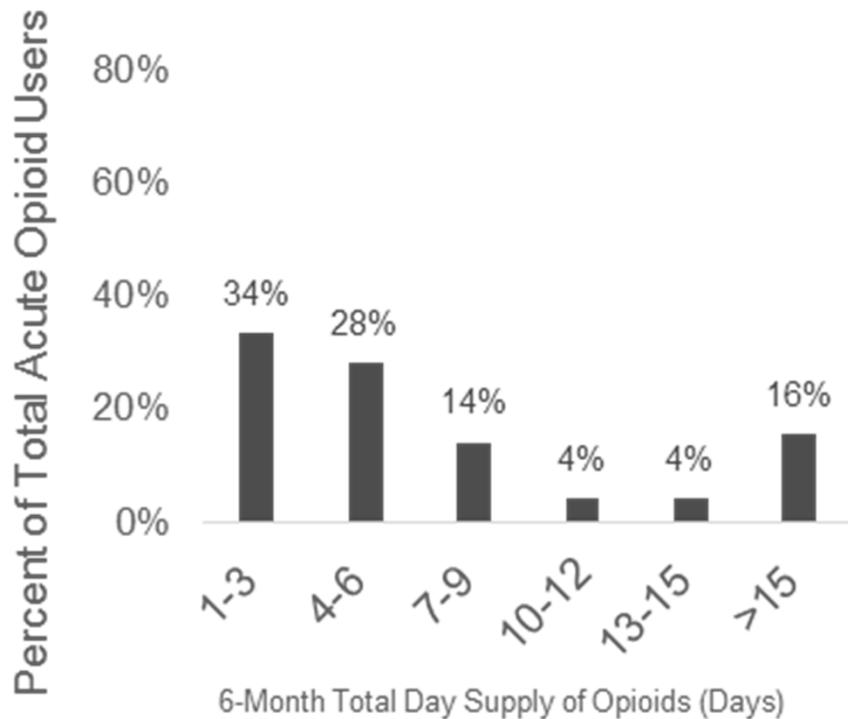
Both statewide & within TennCare, there was a **decrease in NAS cases** for the first time from CY 2016 to CY 2017.

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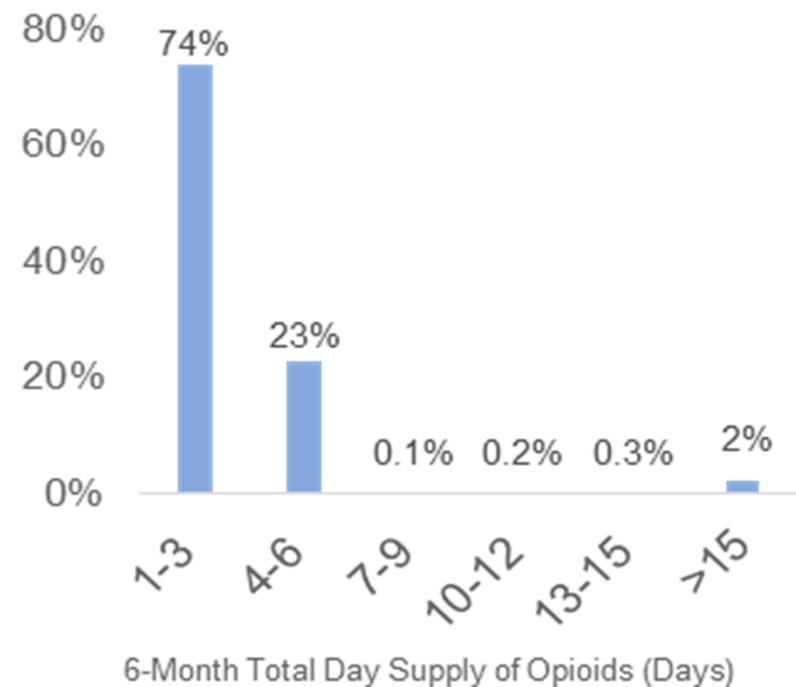
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Combating the Opioid Epidemic

Days Supply Before TennCare Benefit Limit



Days Supply After TennCare Benefit Limit



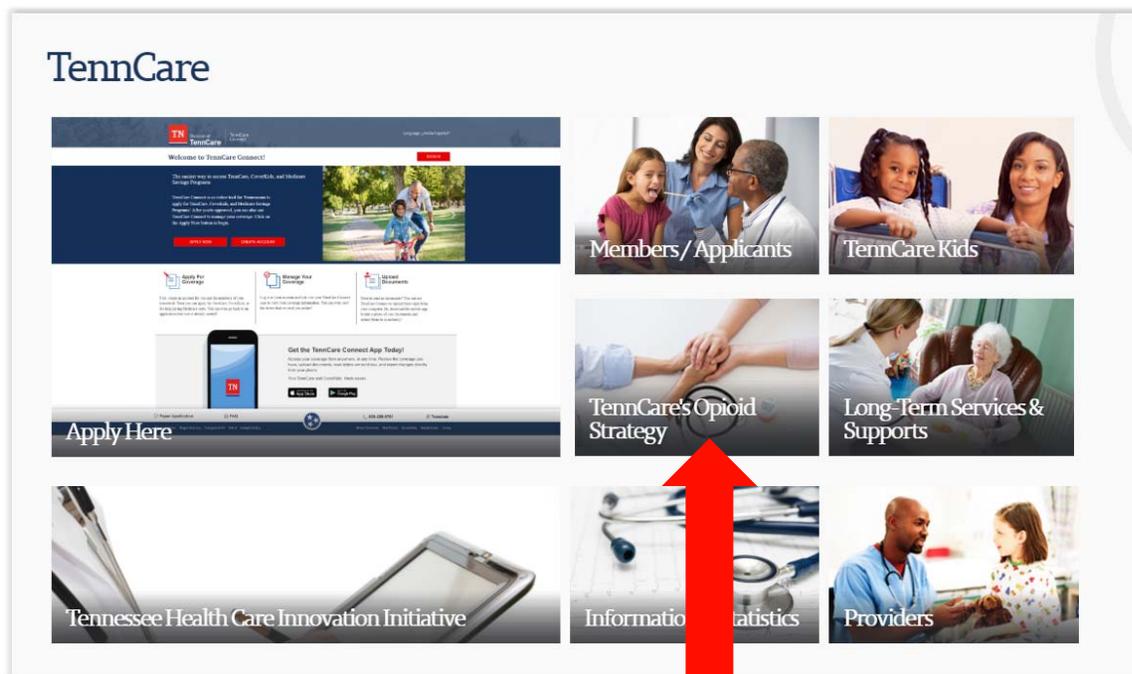
About 97% of all first time and acute opioid users are **now receiving 6 days or less of opioids** after new limits implemented.

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Medication Assisted Treatment (MAT)

- Treatment with buprenorphine for OUD is considered an evidence-based best practice.
- Providers need to understand the MAT program and coordinate with a TennCare MCO to join the MAT network.
- Benefits of contracting as an MAT provider include:
 - Clinical and care coordination support from MCOs
 - Broadened TennCare MAT Pharmacy benefit
 - Increased data on quality and health outcomes
 - Reimbursements from the MCOs for defined MAT services



Visit the TennCare website and click on the **TennCare Opioid Strategy** page to learn more about MAT and complete the MAT Provider Interest Form.

Delivery System Transformation

Changing the way we pay for health care, from paying for volume to paying for value.

Primary Care Transformation



- Patient-Centered Medical Homes cover approximately 500,000 members
- Tennessee Health Link serves approximately 70,000 people with the highest behavioral health needs
- Hospital and ED admission, discharge and transfer (ADT) real time alerts from all hospitals in Tennessee sent to accountable providers

Episodes of Care



- 48 retrospective Episodes of Care
- Episode examples: perinatal, total joint replacement, acute asthma exacerbation, appendectomy, and attention deficit hyperactivity disorder
- \$40.6 million in recurring budget reductions through FY 2019
- Results show savings while quality has been maintained
- Total bonus payments have exceeded total risk sharing payments

Long Term Services & Supports



- New nursing home payment structure takes into account the acuity of residents and the quality of care provided
- Payments to nursing homes for complex respiratory care reduced by 25% with more people weaned from the ventilator and improved use of technology to reduce infections, hospitalizations, deaths

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Amendment 40 – Katie Beckett Program

- TennCare has submitted a waiver amendment to the Centers for Medicare and Medicaid (CMS) after holding its a 30-day public comment period and making final adjustments to the amendment based on comments received. We do not know how long it will take to receive a decision.
- TennCare and DIDD worked together to design a new Katie Beckett Program
 - Program will be for children under age 18 with disabilities and/or complex medical needs who are not Medicaid eligible because of their parents' income or assets
- Program has two parts:
 - Part A for those with the most significant disabilities or complex medical needs
 - Part B designed as a Medicaid diversion program

Tennessee Block Grant Proposal

Base Block Grant

“Base” block grant amount set based on applicable TennCare experience over the last three state fiscal years.

This amount will be trended forward each year based on inflationary projections estimated by the Congressional Budget Office (CBO).

Per Capita Member Growth

Growth in TennCare membership will be accounted for through per capita increases in the block grant amount.

Shared Savings

The difference between what TennCare actually spends and what CMS projects would be spent without TennCare (which is called the budget neutrality cap) will be shared between the federal and state government.

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Projected Timeline

- Per legislation, the block grant amendment must be submitted to CMS by November 20.
- Prior to submission, TennCare must provide a 30-day public comment period. This public comment period will end on October 18, 2019.
- Date of final decision by CMS is unknown.
- If an agreement on the block grant waiver amendment is reached between CMS and the administration, the General Assembly must approve the agreement prior to implementation.

EHR – Contacting Us

General question about the EHR Incentive Program:

- Send your email to:
TennCare.EHRIncentive@tn.gov

Questions about why your attestation was returned

- Send your email to:
EHRMeaningfuluse.TennCare@tn.gov

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

TennCare Provider Services

1-800-852-2683

<http://www.tn.gov/tenncare/section/providers>

Questions?

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